Maternal and Child Health Services
Title V Block Grant

State Narrative for Rhode Island

Application for 2014
Annual Report for 2012

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July 12th, 2013

Michael C. Lu, M.D., M.S., M.P.H
Maternal and Child Health Bureau
Parklawn Building, Room 18-05
Rockville, MD 20587

Dear Dr. Lu:

As with every grant application, we look back at last year and we review our challenges, our successes and what the new focus and direction will be for the upcoming year. And we do it within the broader context of the key policies issues impacting maternal and child health in Rhode Island. The state of Rhode Island's economy, jobs, tax base, health care reform, economic development and recovery, education, and affordable housing, continue to be in the forefront of the public debate and state leadership. The state's safety net infrastructure continues to be impacted by cuts and much attention continues to be on the state's implementation of the national Affordable Health Care Act and the Health Exchange as a way to preserve as much as possible the state's safety net.

Public Health was also impacted in Rhode Island during this year's budget process. The Department's general revenue for SFY 14 was cut by $750,000 and this will impact the state's capacity to deliver on some of its key public health mandates. On the positive side, the legislature added new funding for the Childhood Lead Poisoning Prevention Program which will allow HEALTH to maintain the program for another year given the elimination of federal funding for this purpose. In addition, HEALTH was able to successfully complete the conversion of state contract employee positions into state employee positions, a move that will go a long way to help HEALTH continue its good work in many public health areas. HEALTH also continues to be successful in bringing in new federal grant dollars including, but not limited to, WiseWoman funding to address cardiovascular disease and its risk factors as well as another grant to address the impact of climate change in health. Both of these new initiatives support our response to the public health needs of Rhode Island residents.

As the lead MCH authority in the state, the Division of Community, Family Health and Equity (CFHE) has primary responsibility for assessing the health and developmental needs of young families and children in the state, for planning effective measures to address those needs, for evaluating programs and policies affecting the health and development of women, children, and families in the state and for implementing effective measures to address those needs. We continue to do so by further advancing the implementation of our equity approach to public health built, which is built on the following pillars: addressing the *social and environmental determinants of health and inequities*, applying the *life course approach* across all programs including chronic disease programs, continuing to leverage resources by *integrating* categorically funded programs and building the *social and emotional competencies* of our staff and partners.

We have reaffirmed our goal of achieving health equity for all Rhode Islanders, through eliminating health disparities, assuring healthy child development, preventing and controlling disease, preventing disability, and working to make our environment healthy.

These priorities identified in the 2011 comprehensive needs assessment have not changed. However, during the upcoming fiscal year, the CFHE will focus its investments in advancing those priorities at the local level through the Centers for Health Equity and Wellness (CHEW) initiatives and will work to address some of the issues raised by our community input process as follows:

- **Priority**: Increase access to and capacity to support evidence based parent education and family support programs.
  Invest in major public messaging to caregivers on the importance of healthy early child development (e.g. "your baby is worth the wait" campaign).

- **Priority**: Reduce tobacco initiation among middle school students.
  Invest in a more diversified set of education and life course options (e.g. new adolescent health initiative).

- **Priority**: Increase the percentage of insured adolescents who have a preventive "well care" visit each year.
  Work to create a new model of care for adolescents (e.g. new adolescent health initiative).

- **Priority:** Increase the social and emotional health of children and youth with special health care needs.
  Continue to expand the Pediatric Practice Enhancement Project and secure a reimbursement mechanism.

- **Priority**: Increase the percentage of women who have a preventive care visit in the last year.
  With the release of our Preconception Health Plan work with key state agencies to better align policies and priorities.

- **Priority:** Initiate prenatal home visiting program.
  Continue to *work to better integrate our Home Visiting Program with the primary care delivery system.*

- **Priority:** Adopt the social determinants of health into public health practice.
  Continue to work with all key state agencies and local partners in moving forward with a clear equity agenda that incorporates "health in all policies" by expanding the Centers for Health Equity and Wellness (CHEW).

The CFHE will continue to provide leadership, planning, and infrastructure for HEALTH efforts in responding to these priorities and assuring that families and children needs in Rhode Island are addressed.

As always, we are grateful for MCHB support.

Sincerely;

Ana P. Novais, MA
Executive Director of Health

BUDGET INFORMATION – Non-Construction Programs

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
Maternal and Child Health Services	93.994	$0.00	$0.00	$1,627,190.00	$28,303,071.00	$29,930,261.00
Totals				$1,627,190.00	$28,303,071.00	$29,930,261.00

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e)TOTALS
Maternal and Child Health Services	$441,255.00	$2,008,389.0	$25,853,427.00	$28,303,071.0
TOTAL				

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

The following assurances and certifications are maintained on file in the Division of Community, Family Health and Equity at the Rhode Island Department of Health:

Non-construction program
Debarment and suspension
Drug free work place
Lobbying
Program fraud
Tobacco smoke

Assurances and certifications can be obtained by contacting:

Rosemary Reilly-Chammat, Ed.D.
Division of Community, Family Health & Equity
Rhode Island Department of Health
3 Capitol Hill, Room 302
Providence, RI, 02908
Phone: (401) 222-5922
Email: Rosemary.Reilly-Chammat@health.ri.gov

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

E. Public Input

/2013/ The mission of HEALTH's Title V MCH Program is to build integrated systems that support health, growth, and development for MCH populations, including CYSHCN. The Title V MCH needs assessment is a critical component and requirement of the Title V MCH Block Grant. Community participation in the needs assessment process is an important part to understanding the MCH needs in Rhode Island. In order to understand the needs of the community, a combination of quantitative and qualitative information is required.

The three components of community participation in Rhode Island's five-year Title V MCH needs assessment cycle are: an annual open meeting, an annual community input survey (available in survey monkey and paper format), and annual solicitation of public input from professionals and families who participate in the DCFHE standing program meetings and individuals who participate in other meetings in which DCFHE staff participate. These annual activities are linked specifically

to the Title V MCH application process to facilitate comment from any person during its development.

In addition, Rhode Island has regular mechanisms in place to obtain input and feedback on its MCH programs through advisory and other groups charged with addressing specific programs and issues. Some of these groups are administered by the DCFHE and others are administered by external partners. Input and feedback related to state MCH needs, capacity and priorities are collected at these meetings from participating stakeholders, other state agencies, providers, and consumers which include families with CYSHCN. RI's Title V needs assessment activities and studies occur in an ongoing manner over the five years intervening the required needs assessment development.

Data obtained in calendar year 2010 and early calendar year 2011 was used to develop the Title V MCH FY2011 comprehensive needs assessment process (Year One of the current Five-Year Cycle), which allowed RI to use data to examine capacity, identify priority needs, establish state performance measures, set annual targets for national and state performance measures, identify activities to address priorities, allocate resources, and monitor progress. Results from the needs assessment process and community input provided a comprehensive picture of the MCH population needs in Rhode Island.

In May 2011, the DCFHE, in partnership with RI KIDS COUNT, hosted a meeting to discuss current evidence-based programs that support parents and families. In addition, the DCFHE hosted a community input meeting with over 110 participants representing a diverse mix of over 40 community organizations. Participants participated in breakout sessions based on the state's MCH priority population groups during which the participants identified the major themes impacting each population. Participants in each group engaged in robust discussions about the themes, which including the identification of systems needs for each priority population.

With respect to early childhood, the priority themes identified included family support and involvement, parent education, data sharing, oral health care, prenatal care, and employer supports (maternal depression, breastfeeding, etc.). The state priority established for early childhood for the current five year cycle is to expand capacity and access to evidence-based parent education and family support programs in the early years. The corresponding state performance measure developed for this priority is the percent of resident families with at risk newborns that receive a home visit during the newborn period.

For middle childhood, the priority themes identified included health and wellness, family support and involvement, partnerships/integration with schools, communities and providers, mental health/bullying, access to care, transportation, homeless youth, and oral health. The state priority established for this population is to reduce tobacco initiation among middle school students and the performance measure is the percent of middle school students who have initiated tobacco use.

For adolescence, the priority themes were family support and involvement, access to care (physical, mental health, and contraception), partnerships among youth serving state/community agencies, health and wellness, transportation, homelessness, LGBT, and teen dating violence/bullying). The state priority for this group is to increase the percentage of teens that have an adolescent well care visit each year and the state performance measure is the percent of teens who receive an annual preventive care visit.

For CYSHCN, the themes identify were mental health, access to care/medical home, family support and involvement, health and wellness, and partnerships among schools and communities specific to CYSHCN. The state priority for CYSHCN is to increase the social and emotional health of CYSHCN and the state performance measure is the percent of high school students with special needs who report feeling sad or hopeless.

For women across the lifespan, the themes were access to preconception care, health and wellness/obesity prevention, and preventive care/screening for chronic conditions. The state priority is to increase the percentage of women who have a preventive care visit in the past year and the state performance measure is the percent of women who have a preventive care visit in the past year.

For pregnant women, the themes identified were access to prenatal care, supportive networks for women and children, and prenatal home visiting. The state priority is to initiate a prenatal home visiting program and the state performance measure is the percent of pregnant women delivering babies served by home visiting.

Overarching themes included health and wellness, partnerships, data systems, access to care/medical home, mental health, family involvement and support, and use of evidence-based practices. The state priorities are to promote use of evidence-based programs to support parents and families of all children and to adopt social determinants of health into public health practice. The state performance measures are the percent of adolescents who report food insecurity, and the percent of high school students who earn a high school diploma or diploma equivalent in the 6 core cities //2013//.

/2014/ In FY2013, the DCFHE held an open meeting on June 27, 2012, distributed a community input survey (available in survey monkey and paper format), surveyed people seeking services from Vital Records (birth certificates, death certificates, etc.), and solicited public input from professionals and families who participate in DCFHE standing program meetings and from individuals who participate in other meetings in which DCFHE staff participated throughout the year as a part of the Title V MCH application process for FY2014. The themes that emerged from this year's community input process were similar to the themes that emerged in FY2011, FY2012, and FY2013 which provided assurances and reinforcement that to the DCFHE that its state priorities and performance measures remain both current and relevant. Attached is a summary of the community input received for each priority, a copy of the community input survey, and a notice for the open meeting held on July 27 //2014//.

An attachment is included in this section. IE - Public Input

II. Needs Assessment

In application year 2014, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

/2014/ The needs assessment summary for Rhode Island for FY2014 is included as Attachment IV //2014//.

An attachment is included in this section. IIC - Needs Assessment Summary

III. State Overview

A. Overview

In order to develop and implement priorities for Rhode Island's (RI's) Title V MCH Program, it is first necessary to understand the health needs of the state's entire population and the general health care delivery environment. Equally important is an understanding of the geographical and cultural characteristics of the state, its localities (including their governmental structures), and the state's economic, housing, and educational characteristics since they also impact the health needs of the state's population.

It is also important to understand the key policy issues related to MCH currently being debated in RI's public arenas. Current agenda items include the economy, jobs, unemployment, taxes, ***/2014/ the Affordable Health Care Act//2014, economic development, education, affordable housing, /2014/ gun control, same sex marriage, crime, //2014//*** and welfare reform. However, the state's safety net infrastructure has been damaged by cuts made in response to the fact that RI is struggling to recover from a major economic recession.

/2014/Social safety net programs have a significant impact on the state's budget. In the enacted FY2010 budget, grants and benefits accounted for 46% of the total spending in RI. While spending on these initiatives has always constituted a significant portion of the state's budget, the composition of this spending has changed over time, shifting in RI as well as in the nation, from non-health to health programs, such as Medicaid. In RI, of the growth of spending between 1996 and 2006, 90% went to Medicaid.

According to a report issued by the RI Public Expenditure Council, in 2009, support and services fell short for Rhode Islanders in crisis as well as those seeking long-term assistance. Changes to RI's cash assistance program included the establishment of shorter time limits, stricter work requirements, and stricter sanctions. More recently, reductions in funding for Head Start and affordable housing programs due to sequestration have emerged. At the same time, charitable donations to non-profit social service agencies have declined significantly //2014//.

RI demographic data shows that RI residents are older, more culturally diverse and that the state has fewer workers in their prime productive years. RI residents are less self-sufficient and more reliant on government assistance, requiring continued taxpayer investment in entitlement programs and fundamental public services. At the same time, the majority of the state's voters believe that taxes are too high in RI and the state is not doing enough to lower taxes and spend taxpayer money wisely.

On the positive side, the Affordable Health Care Act provides RI with opportunities to improve health outcomes, delivery and payment systems, and measurement and assessment metrics. In addition, the state's health reform efforts will have far reaching impacts to its economy. The health care and social service sector represents nearly 20% of all private employment in RI and it is expected to grow substantially over the next decade. The expected reduction in the number of uninsured Rhode Islanders under health care reform will increase demand for health care services.

/2014/Families USA estimates that nearly 83,000 of RI's residents will be eligible for new federal insurance subsidies, a central pillar of the Affordable Health Care Act. The vast majority of residents in RI eligible for subsidies are working families and those aged 34 years and under. More than half (57%) of the 83,000 residents eligible for insurance subsidies make between 200% and 399% of the FPL and 87% are in working families. About 15% of eligible residents are 18 or younger, 40% are ages 18-34, 33% are ages 35-54, and 12% are ages 55 and older.

Healthy RI is a project of the Lt. Governor, in conjunction with the Governor's Office' the executive Office of Health & Human Services, the Health Insurance Commissioner, the Department of Health, and the Health Benefits Exchange, focused on the future of the health care system in RI. Healthy RI seeks to chart RI's course from a volume-based health care system to a value-based system. It will be grounded in the priciples of the Triple Aim - better population health and better care experience at a lower cost. It is RI's state innovation model desgn program, an initiative funded by the Center for Medicare and Medicaid Innovation. Healthy RI will produce a plan which will include state goals for health system transformation, identify proposed models for payment and delivery.

At the same time, RI is implementing several innovative new solutions designed to address some of its more vexing health care, education, human services, and economic challenges. /2014/ Key highlights achieved by public health over the past few years in RI include reductions in the rates of cigarette smoking, childhood lead poisoning, and premature births, and the achievement of high rates of childhood immunizations, early prenatal care, and health care coverage for children. RI also leads the nation, along with Massachusetts and Connecticut, for having the fewest deaths of children or teenagers. Acheivements in these areas are measured statewide and for RI's core communities through a variety of databases held in high regard including, but not limited to, CDC, the Census, and KIDS COUNT //2014//.

Geographical & Cultural Characteristics: The state of RI is a small, coastal area (1,214 square miles) with just over one million residents ***/2014/ (1,0506,646 in 2011) //2014//***. The entire state measures just 48 miles, from north to south, and 37 miles, from east to west. Historically, most Rhode Islanders have been White descendants of European immigrants, plus some long established African American families and members of the small Narragansett Native American Tribe.

With the establishment of the first water-powered cotton mill in the nation in Pawtucket in 1793, RI became the birthplace of the industrial revolution in the United States. Since then, waves of immigrants -- from the Italians, Irish, French/French Canadians, and Portuguese in the late 19th century to the Asians and Latinos in the late 20th century -- have come to RI in search of a better life. Currently, 12.5% of Rhode Islanders are foreign-born. Between 2000 and 2010, the number of foreign-born residents in the state increased by 12.6%.

The largest share of the foreign-born population in RI is from Latin America (36.8%), followed by Europe (32.9%), Asia (16.4%), Africa (10.1%), and Northern America (3.5%). Among people at least five years old living in RI in 2005, 20.4% spoke a language other than English at home. Of those speaking a language other than English at home, 48.7% spoke Spanish and 51.3% spoke some other language.

The three largest ancestral groups in RI are Italian, Irish, and French-Canadian. Rhode Island has a higher percentage of Italian Americans and persons of Portuguese ancestry, including Cape Verdeans, than any other state in the nation. Although there are still many more Catholics in Rhode Island than any other religion, the number of Catholics who belong to parishes is down by 14% in RI - enough of a loss to impact its longstanding distinction as the most heavily Catholic state in the nation. That position now belongs to Massachusetts. Currently, 44.3% of Rhode Islanders are connected in some way to the Catholic Church.

Although RI ranks high in percentage of forested land (60%), 75% of its population resides in a 40-mile long urban/suburban corridor along the shores of Narragansett Bay and in the valleys of the Blackstone and Pawtuxet Rivers. This corridor, which includes Providence, contains nearly all of the state's public infrastructure, major transportation routes, and institutional and cultural centers. ***/2014/ Providence, the second largest city in New England after Boston, is a major metropolitan community in which an estimated 178,053 residents live.***

Providence is one of RI's four (4) designated "core" communities, defined as being a city or town in which more than 25% of the children live in poverty. RI's other core communities include Pawtucket, Central Falls, and Woonsocket. Twenty-nine percent (29.4%) percent of the state's population resides in these four (4) core communities, which continue to struggle with crime, education opportunity, and depressed economic conditions //2014//.

According to the U.S. Census 2010, the racial/ethnic distribution of RI's population consisted of Whites (81.4%), Blacks (5.7%), Asians (2.9%), Native Americans (0.6%), Native Hawaiian or Pacific Islander (0.1%), some other one race (6%) and those who identified themselves as being two or more races (3.3%). Also, 12.4% of the population identified themselves of Hispanic or Latino origin.

RI's children are diverse in race, ethic background, language, and country of origin. In 2006, there were 9,848 foreign-born children under age 18 living in RI, representing 4% of the state's child population. In RI, 78% of children ages 5-17 speak only English, 14% of children speak Spanish, 6% speak other Indo-European languages, and 2% speak Asian or other Pacific Island languages.

Of RI's immigrant children, 42% are from Mexico, Central, or South America; 29% are from the Caribbean; 11% are from Europe; 11% are from Africa; and 6% are from Asia. More than three-quarters (78%) of all minority children live in RI's six core communities. RI has the highest percentage of Hispanic children living in poverty (79%) and the fourth largest percentage of black children (71%) living in neighborhoods in which more than 18% of persons are in poverty in the nation.

/2014/ The negative effects of the recession continue to be shown in the data for children in RI. In June 2014, RI was ranked 26th in the nation and last in New England in overall child well-being when looking at factors that include health, education, economic well being and family and community (KIDS COUNT 2013 Data Book). Mirroring national figures, the number of RI children with parents unable to find full-time year round employment has grown. In RI, 35% of children were living with parents without full-time work in 2011, up 1% from the year before and 5% from 2008. The number of adolescents ages 16 to 19 who were not in school and not working also rose. In RI, 7% fell into that category in 2011, a 5% hike from 2010. //2014//.

State & Local Government Structure: RI has advantages for effective public health program implementation, given its small geographical size and unique governmental structure. With the exception of the state court system, there is no county level of government in RI. The state is made up of 39 cities and towns ranging from 1.3 to 64.8 square miles in size. In RI, local communities possess control of areas such as primary and secondary education, subdivision of land and zoning, and housing code enforcement. A combination of cultural, socio-economic, and transportation-related factors makes "the neighborhood" the most important level of community in many parts of RI, especially in the state's low-income, urban communities. ***/2014/ For example, Providence has a tremendous diversity of 25 neighborhood populations //2014//.***

Unfortunately, local revenue sources have been declining in recent years. Between FY2008 and FY2012, direct state aid to cities and towns in RI was reduced by 72.6%. Moreover, as residential property values have seen steep declines in the recent recession, local tax bases have eroded. The resulting pressures on cities and towns to meet service level demands given increasingly constrained resources, coupled with unaffordable expenditure structures that some communities have not modified, have pushed some local governments to the brink of insolvency. In 2012, the City of Central Falls became the first municipality to file for bankruptcy in the state's history.

In 2010, RI elected its first independent Governor, Lincoln D. Chafee. The state legislature, the General Assembly, is a part-time legislature that is in session for about six months each year

(January to June). The state House of Representatives includes 75 members, 87% of whom the Democrats. The state Senate has 38 members, 76% of whom are Democrats.

/2014/ On July 3, 2013, the governor signed an $8.2 million state budget bill for 2014 passed by the state legislature. The budget includes no tax or fee increases, contains numerous economic development initiatives, fully funds the implementation of the school funding formula (the total includes $500,000 for early education programs and $250,000 for an all-day kindergarten pilot program), adds funding for higher education, adds $750,000 in rental assistance to help the homeless, and provides additional funding for cities and towns //2014//.

Key health-related measures passed by the legislature this year (with health being defined broadly) include ***/2014/ an increase in the minimum wage by 25 cents to $8.00 an hour effective January 1, 2014, extended paid temporary disability insurance (TDI) leave benefits to workers caring for newborns or sick relatives, an extension of collective bargaining rights to home-based child care providers, the creation of a pilot program to allow families receiving state subsidized child care to remain in the program if their income increases exceed the current limit of 180% of the FPL, allowing them to earn up to 225%, increased penalties for some gun crimes, the passage of same sex marriage legislation effective August 1, 2013, prohibition of employers from initially asking applicants about their criminal histories, and bans on the sale and manufacture of "synthetic" marijuana, "bath salts", and other recreational drugs. The legislature also passed a number of economic development proposals, including a plan to create a new governor-appointed secretary of commerce to serve as a primary advocate on economic and business matters.***

Failed health-related legislation included proposals that would have banned assault style, semi-automatic weapons and high capacity ammunition magazines; put in place a 36% cap on annual interest for short-term payday lending loans; prohibited using welfare benefits on alcohol, lottery tickets, or tobacco products; repealed the state's 7% sales tax; increased taxes for high-income earners; eliminated a requirement, effective 2014, to show a valid picture identification before voting; required "foreign nationals" to obtain RI driver's licenses; and banned employers and schools from requiring access to applicants' social networking accounts.

The legislature also rolled back parent eligibility for RIte Care (the state's Medicaid managed care program) from 175% of the federal poverty level (FPL) to 133% of the FPL, effective January 1, 2014. The 6,500 parents currently enrolled in RIte Care will lose their coverage and will have to seek commercial health insurance coverage through the new RI Health Benefits Exchange. Federal tax credits will be available to help parents pay for coverage. The budget also includes some state funds to help pay for monthly premiums.

Also beginning January 1, 2014, families will no longer need to pay monthly premiums for their children to have RIte Care coverage. The 5,600 families with income above 150% of the FPL, who currently pay between $61 and $92 per month will no longer have to pay for RIte Care. This change ensures that children will no longer lose RIte Care coverage if their parents cannot afford to pay. It will also prevent families from having to pay two monthly premiums for health insurance for their families -- one to the state for their children for RIte Care and one to the commercial insurance company to cover themselves.

The RI Department of Health (HEALTH) is the sole public health authority making it legally responsible for the provision of core public health activities at both the state and local levels. HEALTH contracts for the provision of most non-regulatory services rather than deliver them directly. This strategy helps to create a seamless, uniform quality public health service system in RI. The absence of local health authorities means that health care providers in the state look to HEALTH for policy guidance and other forms of

assistance.

/2014/ HEALTH enjoys a partnership with Brown University's schools of Medicine and Public Health. In recent years, Brown University and HEALTH have worked together to document and mitigating lead exposure in RI's children, respond to the H1N1 flu, assist with statewide vaccination campaigns, and help people quit smoking and overcome other addictions, and develop programs to give low-income people access to fresh fruits and vegetables. Public health faculty also works with Brown's Medical School to plan a new track for medical students focused on primary care and population health //2014//.

RI is an ideal site for innovation in health care. It's a state of "one" -- "one" hour to every geographic corner, "one" thousand square miles in size, "one" major metropolitan area (Providence), "one" department of health, and "one" medical school (Brown University School of Medicine). This makes it relatively easy to gather everyone in one room to work on "one" health topic in RI. The state's Title V MCH Program is located in HEALTH within the Division of Community, Family Health & Equity (DCFHE).

Economic Needs of the State's Population and Select Innovative Solutions: Although the US recession ended in the summer of 2009, RI's recession stretched into early 2010. Since then, the recovery has been both slow and uneven. ***/2014/ In May 2013, RI's unemployment rate was 8.9%, the third highest rate in the nation, after Illinois and Mississippi. RI's unemployment rate was also the highest in New England. In contrast, the national unemployment rate was 7.6% in May 2013.***

On the positive side, state officials heard a generally positive economic forecast from a consultant during the state's May 2013 revenue estimating conference. While the effects of the federal sequester, the fade-out of a payroll tax cut, and other fiscal policies are a drag on the economy, the situation will improve as the year progresses, said a senior economist with Moody's Analytics.

Housing will be a big contributor to economic recovery going forward. RI's housing sector is solidifying as the number of problem mortgages falls while the number of building permits rises. Construction was the hardest hit sector in the RI job market in the 12 months ending in March 2013. The sector will see a small gain in employment during the next two years. While things are not as bad as recent years, RI's recovery is still fragile and continues to lag behind it neighboring New England states and the rest of the country //2014//.

One factor in RI's high unemployment rate, frequently mentioned by economists, is the lack of a skilled workforce that matches what employers need. In the changing economy, it is difficult to find RI workers trained for jobs in such fields as health care and technology. Forty-eight percent (48%) of RI's jobs are in the "middle skill" category, but only 37% of the workforce has the skills to fill these jobs. Another potential risk to the state's recovery includes, but is not limited to, sustained weaknesses in the housing market.

/2014/ The state's FY budget includes $4.5 million, some from federal sources, for workforce development. Among the programs is the Back to Work Program, which will pair a person collecting unemployment benefits with a business for training at no expense to the business, which could then hire the trained employee if it chooses. Another program included in the budget is the Jobs Match Program which will use a computerized system to match employers and job-seekers and identify skills gaps in the workforce //2014//.

Crime in Rhode Island and Select Innovative Solutions:

/2014/ In April 2013, the Governor and leaders in education, law enforcement, and health

care announced a package of bills being introduced in the General Assembly that they say will improve safety in RI's schools in the wake of the massacre in Connecticut. The bills would replace a school safety law enacted in 2011 after the Columbine school shootings, with new, more expansive legislation. The package of bills was passed.

As noted, the legislature passed a bill this year to ban public and private employers in RI from asking a job applicant if he or she has a criminal record until the first interview. Eight other states, including Massachusetts, have passed similar legislation. Advocates say the legislation ends discrimination against people with criminal records by prohibiting the disproportionate screening out of black and Latino males along with a rapidly growing number of females.

Also in this year, RI became the 15th state to decriminalize possession of an ounce of less of marijuana. The change means that anyone caught twice within 18 months with an ounce of less of marijuana will receive a $150 ticket. But a third infraction within that period results in a misdemeanor charge //2014//.

Educational & Child Care Needs of the State's Population and Select Innovative Solutions: RI is lagging its New England neighbors in terms of educational achievement. According to the US Census, 83.7% of Rhode Islanders age 25 years and older have a high school education. In contrast, the percentages are higher for the United States (85%), New Hampshire (90.9%), Vermont (90.6%), Maine (89.8%), Massachusetts (88.7%), and Connecticut (88.4%). Although the percentage of Rhode Islanders age 25 years and older who have a bachelors degree or more (30.3%) is higher than the percentages for the nation (27.9%) and Maine (26.5%), it is lower than the percentages for Massachusetts (38.3%), Connecticut (35.2%), Vermont (33.3%), and New Hampshire (32.9%).

RI's public education students are a diverse group. On October 1, 2011, 64% of RI's 142,854 public school students were non-Hispanic White, 22% were Hispanic, 8% were Black, 3% were Asian/Pacific Islander, 3% were Multi-Racial, and 1% were Native American. Forty-four percent (44%) were low-income. Eighteen percent (18%) were receiving special education services and 6% were receiving English as a Second Language (ESL) or bilingual education services. RI's ESL students spoke 77 different languages. The majority spoke Spanish (75%), followed by Asian languages (8%), Creole or Patois (8%), Portuguese (4%), African languages (1%), and other languages (5%).

In 2011, the four-year high school graduation rate in RI was 77%. The four-year high school graduation rate is the number of RI students who graduate in 4 years or fewer divided by the total number of students who started 9th grade in 2007-2008, adjusted for transfers in and out. During the 2010-2011 school year, 90% of RI's high school seniors reported planning to attend a 2-year or 4-year college. In 2011, 64% of RI's graduating seniors had taken the SATs. However, only 35% of those who took the SAT achieved a score that indicated likely success in college and in the work force.

More than half (53%) of RI's 18-24 year olds were enrolled in college in 2009, a higher percentage that any other state. Two-thirds (66%) of RI students enrolled in 4-year colleges graduated within 6 years, higher than the national rate of 56%. Among RI students enrolled in 2-year colleges, 12% graduated within 3 years, lower than the national rate of 29%. This rate does not include the 20% of 2-year college students that transferred to 4-year colleges. Between 2008 and 2010, and estimated 4,407 (7%) youth ages 16 to 19 were not in school, not in the Armed Forces, and not working in RI. Forty-three percent (43%) of these youth were high school graduates and 57% had not graduated from high school. In 2011, RI raised its school attendance requirement from age 16 to 18.

/2014/ Of the students who enrolled in the state's two-year community college in the fall of 2013, 97% graduated from a RI high school within the previous year. Among those 2,250

recent high school graduates, just over 70% needed some sort of remedial course, whether it was math, English, or writing. The biggest need was for remedial math -- 65.7% - didn't pass the math requirement. In addition, 47% had to take remedial reading and 36% of the recent high school graduates were required to take remedial writing //2014//.

RI has started to implement an ambitious public education agenda, and it is beginning to see results, such as the growing number of students achieving proficiency on the New England Common Assessment Program (NECAP) assessments. Additionally, for the first time since the National Assessment of Educational Progress (NEAP) was first administered, RI's 4th graders scored above the national average on mathematics assessment. At the same time, it is evident that much work remains. RI ranks 6th highest in the nation for per pupil education expenditures, but 29th in 8th grade NEAP mathematics and reading performance. Further, RI underperforms relative to other national and regional averages on the SAT and has higher percentages of adults without at least a high school diploma than the other New England states and the nation.

The state, working with local school districts, has moved forward on a number of key initiatives central to its strategic plan for public education, such as finalizing implementation of a Uniform Chart of Accounts, adopting Common Core Standards, and developing an educator evaluation system. These reforms have garnered national attention and were key parts of the state winning a $75 million grant in the Race to the Top competition in August 2010. RI was one of only 12 states in the nation awarded Race to the Top funding, which it will utilize over four years to implement a statewide approach to addressing challenges faced by RI's public education system.

/2104/ In 2015, RI will introduce a new standardized education assessment test, the Partnership for Assessment and Readiness for College and Careers (PARCC), which will replace the New England Common Assessment Program (NECAP). The new test represents major change in several major ways. It will be performed on a laptop, given twice a year, and test every grade from grade 3 through grade 11. The NECAP dos not test students in grades 9 and 10. It will be shared by 22 states, including Massachusetts and New York. For the first time, a test will be able to make state-to-state comparisons of students in English, Writing, and Math. The new assessment is part of the "common core", a set of uniform standards in English and Math created by the National Governors Association and the Council of Chief State School Officers ***//2014//.***

RI's investments in early childhood education paid off significantly when Rhode Island was one of just 9 applicants to receive a federal Race to the Top Early Learning Challenge grant in December 2011. The state will receive $50 million to strengthen and improve early childhood programs, training for teachers, and outreach to parents. In addition, the state's education-financing formula calls for $10 million to be added to public pre-kindergarten over 10 years. Five participating state agencies share responsibility for implementing the reform strategies and achieving grant outcomes, including the Departments of Education (the lead agency); Human Services; Children, Youth, and Families; HEALTH (the DCFHE); and the Executive Office of Health & Human Services.

Housing Needs of the State's Population and Select Innovative Solutions: /2014/The number of RI houses lost to foreclosure fell 23% in 2012 compared with 2011, according to a report issued by Housing Works in March 2013. The non-profit group has tracked foreclosure deed filings since 2009, a year in which 2,840 houses in the state were foreclosed. In 2011, the number fell to 2,095, and in 2012, it was 1,617. From January 2009 through December 2012, 8,445 residential foreclosure deeds were filed throughout RI, representing 4.58% of RI's mortgaged housing stock.

Although the number of foreclosures is down, persistently high unemployment and housing costs continue to keep many in the state on the brink of foreclosure. In the fourth quarter of 2012, 7.78% of mortgages in Rhode Island were "seriously delinquent," meaning that payments were 90 or more days late. Many homeowners are cost-burdened, meaning that they spend more than 30% of their incomes on housing costs. In Rhode Island 4 in 10

homeowners are cost burdened and 17.2% are severely cost burdened, meaning that they spend more than 50% of their incomes on housing. Housing is considered affordable if it consumes no more than 30% if household income.

RI has cycled through the bulk of troubled loans that originated during the housing bubble years, and most foreclosures today are linked to the state's high unemployment rate. In 2012, more than 16,000 calls were placed to the United Way's 2-1-1 in RI telephone help line by people seeking help on foreclosure prevention. This was a 64% increase in calls. Other homeowners have turned to the courts to prevent a foreclosure. The Foreclosure Mediation Program at the US District Court recently reported a caseload that topped 700 over the course of 2012 //2014//.

According to a report issued by Housing Works RI in February 2012, nearly 40% of Rhode Islanders rent their homes, more than any other New England state, and 27% of these renters are paying more than half their incomes for housing. Rental costs have spiked while the foreclosure crisis has driven more people into the rental market. For example, the average cost of a 3-bedroom apartment was $1,531 in 2010 -- 75% higher than in 2001. During the same period, the average rent for a 2-bedroom apartment increased by 50%, while the cost for a 1-bedroom apartment jumped 47%.

Rhode Islanders renters earn far less than homeowners. Renters have a median household income of $29,864, far below the median income of the state's home-owning households, $75,553, and less than the statewide median household income of $54,902. Many renters are families. Forty-six percent (46%) of RI renters are living in family households. Renters are almost evenly divided by educational attainment, with 21% having a bachelor's degree or above, 28% having some college or an associate's degree, 29 % having completed high school, and 23% having less than a high school diploma.

/2014/ As a way to help the homeless, legislators added $750,000 in rental assistance in the state's FY2014 budget. The budget also includes and appropriation from the RI Capitol Fund of $1 million for renovation of Harrington Hall, a major homeless shelter in Cranston //2014//.

Social Service Needs of the State's Population & Select Innovative Solutions: Struggling with a lingering recession and high unemployment, more Rhode Islanders fell below the poverty line last year, according to the US Census. The poverty rate in the state rose to 14% in 2010 from 11.5% in 2009 (under 100% of the federal poverty level). Seventeen percent (17%) of Rhode Islanders live in near poverty (100%-200% of the FPL).

The state's poverty rate, the highest in New England, is less than the nation's 15.3% rate. After RI, Maine had the highest poverty rate in New England at 12.9%. The poverty rate for Blacks in RI is 36.5%, nearly four times that of whites (9.4%). The poverty rate for Hispanics is 30.3%, more than three times the rate for whites. People with disabilities are more likely to be living below or near poverty (49%) than all Rhode Islanders (31%).

Nearly one in five children struggles with poverty. According to RI Kids Count, 19% of Rhode Island's children lived in poverty in 2010. The state's childhood poverty rate increased to 16.9% in 2009, from 15.5% in 2008. The nation's child poverty rate was 21.6% in 2010, up from 20% in 2009 and 18.2% in 2008. RI ranked 22nd in the country for child poverty. Fourteen percent of children in RI had at least one parent who was jobless in 2010.

According to a report issued by the non-profit Corporation for Enterprise development in Washington, DC, in January 2012, one in five Rhode Islanders lacks the money needed to weather a job loss, a major medical bill, or other financial crisis. They are "asset poor" workers with little or no savings or other assets to cover 3 months of expenses if they lose a job or face an emergency.

RI ranks 38th in the nation in the financial security of its households, far behind New England's other states. High housing costs helped lower RI's overall score, earning the state an "F" in housing and home ownership, among the worst in the nation. At United Way RI, the number of calls to the agency's 2-1-1 hotline is up sharply. During the first 9 months of 2011, the number of calls from Rhode Islanders seeking food jumped by 206% compared with the same period the year before. The number of foreclosure-related calls increased by 115%.

Since the start of the recession in 2007, the number of Rhode Islanders getting free food from pantries, soup kitchens, and other programs has increased by nearly 60%, according to the RI Community Food Banks "2011 Status Report on Hunger in RI". About 60,000 people a month receive food from the 117 food pantries, 27 meal programs, and 7 shelters served by the Food Bank, an 8% increase over 2010. About 60% of those who get groceries from food pantries also rely on Supplemental Nutrition Assistance Program (SNAP) benefits. Minorities and families with children have been especially hard hit by the economic downturn. About 16% of emergency food program users are Black; 35% are Hispanic or Latino.

Food stamp use is at a record level. ***/2014/ In 2012, the number of Rhode Islanders relying on food stamps reached a record yearly average of 75,023 people, a 6.6% increase from the year before. As of March 2013, the number of participants in the SNAP Program increased to 181,567 people, which is nearly one out of every five people. The average household receives $252 a month for food.***

Legislation introduced since at least 2006 in RI includes a proposal that would cap at 36% the amount of interest that "payday lending" companies can charge individuals //2014//. In RI, payday lenders are allowed to provide small, short-term loans up to $500 that are intended to be paid in full in 2 weeks and are typically secured with a post-dated check. State law allows these lenders to assess what amounts to an annual interest rate of up to 260% on the loans. Rhode Island is the only state in New England that permits the loans, which are also known as "cash advances". The bill failed to pass.

Health Care Needs of the State's Population & Select Innovative Solutions: Like elsewhere in the nation, assuring the health of RI's women and children presents challenges. Of the six New England states, RI has the second highest rate of low birth weight births along with Connecticut (8%), the second highest rate of adult women who are overweight or obese (57% in 2010), the second highest rate of high blood pressure among adult women (28.6%), and the second highest Chlamydia rate (457.4 per 100,000 women in 2010). On the positive side, RI enjoys the highest rate of adult women who had a cholesterol check within the past five years (85.7% in 2009) of the six New England states.

/2014/ In 2013, Rhode Island received the Virginia Apgar Prematurity Campaign Leadership Award from the national March of Dimes to honor the state for a reduction in the rate of premature births. Rhode Island's preterm birth rate dropped to 10.4% in 2011; down from 11.4% in 2009. In RI, the Department of Health and Women & Infants Hospital established a statewide task force on preterm birth and infant mortality, which has led to efforts to decrease tobacco uses among women of childbearing age and to eliminate elective deliveries before 39 weeks, among other initiatives //2014//.

With respect to children's health, of the six New England states, RI has the highest childhood obesity rate (30.1% in 2007); the second highest rate of children (2-17 years) with emotional, developmental, or behavioral problems (76% in 2007); and the highest rate of children (1-17 years) with oral health problems (26.4% in 2007).

On the positive side, RI finished the influenza season in May 2012 after having increased influenza vaccination by at least 10%, with 91.5% of children aged 6-35 months getting vaccinated. RI's vaccination rates remain among the best in the country. In addition, of the six

New England states, RI has the highest rate of children (0-17 years) who had both a medical and dental preventive care visit the previous year (85.3% in 2007), and is tied with Connecticut as having the second lowest teen (15-19 years) death rate (39 per 100,000 teens in 2008).

According to a report issued by CDC in April 2011, RI's teen birth rate from 2007 to 2010 fell 24% - the third steepest decline in the nation. In 2010, the state had the 7th lowest teen birth rate in the country, though its rate remains the highest of the New England states. Yet, the teen birth rate in some communities has remained stubbornly high. The teen birth rates are highest in Providence, Pawtucket, Central Falls, and Woonsocket, which account for 70% of all teen births from 2006 to 2010.

Legislation was introduced this year that would provide family planning services to low-income, Medicaid-ineligible women of childbearing age up to 250% of the federal poverty level. With fewer births, the state would stand to cut its Medicaid spending by $272,000 in the first year of the program and by more than $4 million a year once the program has been running for several years. The proposal would also mirror language in 22 other states that provide such coverage. The bill failed to pass.

According to a recent report issued by the Trust for Health and the Robert Wood Johnson Foundation in May 2012, RI ranks 9th lowest for injury-related fatalities and was graded 8 on a scale of 10 for its efforts to prevent injuries. The state earned points for its laws requiring seat-belt use, child booster seats, and bike helmets for children. It also scored for its efforts to prevent domestic violence and teen dating violence, monitor prescription drug abuse, and protect youth from sports-related concussions.

/2014/ RI is one of five states singled out by the US Department of Agriculture to receive additional technical assistance in expanding its free lunch program during the summer. About 50,000 RI children receive a free or reduced price lunch during the school year. But that number drops to 8,000 children in the summer, according to the USDA. RI is attempting to engage more sites across the state. Because of its small size, RI receives very little money to administer the nutrition program. It is hoped that the additional help from the USDA will help the state address existing barriers and make improvements //2014//.

Between 2000 to 2010, the incidence of childhood lead poisoning in RI declined from 6.1% to 1% and the number of new cases declined from 1,740 to 252. However, nationwide, the budget that CDC allocates for healthy homes and lead poisoning prevention has dropped from $29 million to $2 million. Two years ago, the state received $850,000 from CDC for lead poisoning prevention and control; this was reduced to $594,000 in FY2012 and cut to $0 for FY2013. At its peak, RI received over $1 million from CDC for lead poisoning prevention and control.

/2014/ In May 2013, advocates and families affected by childhood lead poisoning testified in support of legislation that would guarantee funding for the state Childhood Lead Poisoning Prevention Program every year. In years when federal funding is lacking, the bill would require the state to appropriate no less than $600,000 for the program. Providence Plan, a Providence-based social service agency, has estimated that 19% of kindergarteners in Rhode Island have elevated blood lead levels, with the rate soaring as high as 35% in urban areas where poverty and older housing are more predominant. The agency has estimated that special education costs for children with lead poisoning were $17 million in 2012. The bill passed.

RI is on track to develop and launch one of the key provisions of the Affordable Health Care Act -- a state run website where residents and business owners will be able to compare and purchase health insurance plans. Rhode Islanders who do not receive health insurance through their employers -- or work for businesses with 50 or fewer employees -- will be able to use the RI Health Insurance Exchange to compare and purchase health

care. They will also be able to determine if they are eligible for federal subsidies for their insurance premiums. The Exchange will develop ways to rate and analyze how effective insurance plans are in keeping members healthy. This information will help Rhode Islanders and businesses make better decisions about health care and, hopefully, influence insurers to improve benefits. The exchange will start enrolling people on October 1, 2013 for health plans that take effect January 1, 2013 //2014//.

With respect to dental health, it is important to understand that dental insurance is not available to many working families in RI. Fewer than half (48%) of Rhode Island employers offer dental insurance to their full-time employees, and 14% offer it to their part-time employees. Despite this, the percentage of RI women who had a dental visit in 2010 within the past year was 79%, which ranked RI higher than the nation (71.7%) and the third highest of the six New England states. State law requires schools to provide dental screenings for all newly enrolled students, annually for children in grades K through 5, and at least once between grades 7-10.

Still, there are significant numbers of Rhode Islanders who have inadequate access to dental care. In response to this concern the Inaugural Rhode Island Mission of Mercy (RIMOM) was launched at the Community College of RI in Lincoln in June 2012. Though this initiative, free dental services were provided to hundreds of patients with a high priority on those suffering from infections or pain. Patients lined up for services the day before the event and demand for services quickly exceeded capacity. HEALTH staff from the DCFHE's Oral Health Program and Center for Public Health Communications was instrumental in organizing the RIMOM and participated as event volunteers. ***/2014/ In June of 2013, the second RIMOM was held //2014//.***

A CDC study released in October 2011 based on data collected by the National Survey on Drug Use and Health (NSDUH) found that among all states, RI has the highest percentage of adults who made plans to commit suicide and who attempted suicide. It also ranked higher than regional and national averages -- but not at the very top -- in the number of people who had serious thoughts about suicide. The findings came on the heels of a report issued two weeks before which found that RI had the highest rate of mental illness in the nation, 24.2%.

The study found that suicidal thoughts and attempts were higher among females, young adults, and adolescents. Among other findings: 6.2% of adults had serious suicidal thoughts in the previous year (nationally, the rate was 3.7%), 2.8% of adults in RI reported making suicidal plans (nationally, the rate was 1%), 1 in every 67 adults in RI attempted suicide in the previous year (nationally, the rate was 1 in every 200 adults). In 2010, 38.2% of RI adult women reported poor mental health in the previous 30 days. This rate was the third highest in New England after Vermont (43%) and Maine (39.9%).

According to NSDUH data, RI is the worst state in the nation with respect to the percentage of people age 12 and over who have used illicit drugs in the past month -- 13.3%. Rhode Island also ranks in the highest fifth for the category for youth ages 12-17 years -- second of all states at 12.4%. For those Rhode Islanders who need treatment for substance abuse, but are not getting it, RI was in the highest group ranking second at 3.9%. With respect to those ages 12-17, the state remained in the top fifth, in 6th place at 4.9%.

RI has the 3rd highest rate of non-medical use of opioid drugs (6.13%) among people 12 and older. The national rate is 4.8%. At 17.2 per 100,000 population, RI also has the 7th highest rate of drug overdose deaths in the nation and the highest rate of drug overdose death rates in New England. In response to this epidemic, HEALTH is utilizing federal grant funds from the US Department of Justice to electronically enhance its current prescription monitoring program to further reduce "doctor shopping" and diversion, share data with other states, and provide pharmacists and physicians with prescription drug usage information on their patients.

/2014/ During March and April 2013, twelve people died in RI after apparently using a new synthetic opiate that is not heroin. The drug was identified as a never-before-seen variant

of the narcotic acetyl fentanyl. The drug is not approved by FDA and is not prescribed by physicians. The deceased were intravenous drug users. One was 19 and the rest ranged in age from 23 to 57. Little is known about where or how the drug is made, what it looks like and whether it is more powerful than other opiates. A treatment option in Rhode Island is now available without a prescription. Four pharmacies are approved to dispense the drug Narcan used to reverse the effects of opiate overdose. The drug is being made available as part of a pilot project with Miriam hospital.

In March 2013, the state Senate passed two drunken driving bills. One bill would mean anyone older than 18 found guilty of driving under the influence with a child 12 years or younger in the vehicle would face up to five years in prison, $5,500 in fines and assessments. A driver's license could be suspended immediately, not until after conviction, and that suspension could be for up to two years after conviction. Current law carries a maximum one-year sentence. The other bill would require those who are convicted of refusing to take a chemical test to determine their blood alcohol level to have to wait five years before they can apply to the court to have the conviction expunged, rather than the current three years.

Legislation was enacted in 2013 which will ban entire classes of substances being sold in RI as incense and bath salts, but slyly marketed as recreational drugs such as fake marijuana. During the past year, three people have died from using over the counter products sold as bath salts -- but used as recreational drugs -- and some doctors say store bought fake marijuana products may have driven some people to kill themselves //2014//.

HEALTH's Refugee Health Program serves about 148 newly arrived refugees each year. The greatest percentage of refugees arrive from Asia, mainly from Bhutan and Myanmar, and they are followed by Africans and Eastern European refugees. Thirty-nine languages are being spoken. The Program is working to increase the percentage of refugees to 100% for whom a health screening form is submitted by community health care providers to the program within 30 days of the refugee's arrivals a CQI initiative.

In late 2011, RI was awarded competitive federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program funds to provide voluntary, evidence-based home visiting services to pregnant women and children through three years of age in the estate's core communities to improve maternal and child health; prevention of child injuries, child abuse, and child neglect; reduce emergency department visits; improve school readiness and achievement; reduce domestic violence, improve family economic self-sufficiency; and improve coordination and referrals to other community-based supports. Administered by the DCFHE, the MIECHV Program has opted to implement the following evidence-based home visiting models: Nurse Family Partnership, Healthy Families America, and Parents as Teachers.

HEALTH and its lead maternal and child health division, the DCFHE, have been able to look beyond these challenges and implement several innovative strategies for addressing the public health needs of RI's population, including its maternal and child health populations. It is particularly proud of its work to eliminate disparities, coordinate care, promote primary prevention, optimize access to care for all Rhode Islanders, and build the community's capacity to stay healthy. ***/2014/ In the upcoming year, the DCFHE will use Title V funds to support an array of activities including, but not limited to, the integrated MCH/chronic disease initiative known as CHEW, the MCH hotline and distribution center, the BRFSS, health equity grand round activities, the Toddler Wellness Overview Survey (TWOS), PRAMS, parent consultants, Family Voices, the RI Parent Information Network (RIPIN), YSHCN, Pediatric Practice Enhancement Project (PPEP), Teen Outreach Programs (TOP), Ready to Learn Providence, asthma health resources and action services, and the Title V needs assessment. Next year (FY2015) will be the first year of RI's next five-year Title V MCH cycle //2014//.***

As the lead MCH authority in the state, the DCFHE has primary responsibility for assessing the health and developmental needs of young families and children in the state, for planning effective measures to address those needs, for evaluating programs and policies affecting the health and development of women, children, and families in the state and for implementing effective measures to address those needs. The DCFHE's approach to public health is built on the following three pillars of health equity: the social and environmental determinants of health, the life course approach, and the integration of categorically funded services with other categorically funded services.

When allocating resources and making decisions on what interventions should be implemented, the DCFHE uses the "Equity Pyramid" (adapted from Thomas Frieden, MD, MPH, presentation at the Weight of the Nation Conference, in Washington D.C., July 27, 2009) as a tool to help prioritize its work. The "Equity Pyramid" establishes five levels of program impact/effectiveness from level one (less impact) at the top of the pyramid to level five (most impact) at the bottom of the pyramid. The DCFHE has also created grant review guidelines and protocols to ensure that all applications for funds and work plans reflect the three pillars of equity. Core competencies for staff have been identified and professional development opportunities offered to all staff to increase health literacy and understanding of the core domains of health equity.

During the 2011 Title V MCH needs assessment year, the DCFHE identified new MCH priorities informed by data collection and surveillance, family and community input, and interagency collaboration. These priorities have not changed. State Performance Measures 2-6 mirror the identified priorities reflected in the themes based on data and community input. State Performance Measures 1 and 7 are related priorities based on a life course perspective for prioritizing health care needs and services by looking at health and wellness across the lifespan.

The measures are for specific populations yet our intent and purpose is an overarching priority across all of the MCH population groups. State performance measures 8 and 9 are indicators of the social determinants of health. Most health disparities affect groups that are disadvantaged or marginalized because of their socioeconomic status, race/ethnicity, gender, sexual orientation, disability status, geographic location, or any combination of these. Access to healthy food and quality education are social determinants that contribute to good health.

DCFHE convened an internal MCH planning group. This group met monthly to discuss integrative opportunities around MCH priorities and related performance measures. Community input has been analyzed by the group and incorporated into division and program level work. DCFHE programs conduct on-going needs assessment as part of their usual activities around planning, implementation and evaluation of specific initiatives. DCFHE programs consider each opportunity for interaction with the community as a form of needs assessment.

The DCFHE has also developed tools and resources for staff to incorporate a lifecourse development approach that addresses the determinants of health as a framework for health planning across programs. DCFHE leadership has fostered sensitivity to local needs by intentionally demonstrating that it has heard and will strive to meet community needs as they relate to maternal and child health issues. ***/2014/For FY2014, the DCFHE's priorities and measures for action under Title V continue to be as follows:***

- ***Early Childhood: Increase access to and capacity to support evidence based parent education and family support programs.***
- ***Middle Childhood: Reduce tobacco initiation among middle school students.***
- ***Adolescence: Increase the percentage of insured adolescents who have a preventive "well care" visit each year.***
- ***CYSHCN: Increase the social and emotional health of children and youth with special health care needs.***
- ***Women Across the Lifespan: Increase the percentage of women who have a***

preventive care visit in the last year.

- ***Pregnant Women: Initiate a prenatal home visiting program.***
- ***Overarching Priorities: Adopt the social determinants of health into public health practice //2014//.***

Through ongoing partnerships with community advocates, providers, and the families the DCFHE serves, the DCFHE is committed to realizing these priorities and ensuring that all families in our state have the opportunity to raise safe and healthy children in safe and healthy communities. The DCFHE has utilized these processes to determine the importance, magnitude, value, and priority of competing factors impacting health services delivery in the state, including the current and emerging issues and has chosen to use Title V funds to, among other things, support an RFP to provide integrated evidence-based maternal and child health/chronic disease evidence-based services with a focus on addressing health inequalities in targeted neighborhoods in RI.

B. Agency Capacity

B. Agency Capacity

The Title V Agency's capacity to promote & protect the health of all mothers and children Including CSHCN: Chapter 23-13 of the Rhode Island General Laws (1937, 1999) designates the RI Department of Health (HEALTH) as the state agency responsible for administering the provisions of Title V of the federal Social Security Act in Rhode Island relative to MCH services. Michael Fine, MD has served as Director of Health since 2011. In this role, Dr. Fine oversees the single state agency with over 400 employees and an operating budget of over $110 million. Dr. Fine's career as both a family physician and manager in the field of health care has been devoted to health care reform and the care of underserved populations.

Before his confirmation as Director of Health, Dr. Fine was the Medical Program Director at the Rhode Island Department of Corrections; Founder and Managing Director of Health Access RI (the nation's first statewide organization making prepaid, reduced fee primary care available to people without employee-sponsored health insurance); Physician Operating Officer of Hillside Avenue Family & Community Medicine (the largest family practice in the state); Physician-in-Chief of the Rhode Island and Miriam Hospitals' Department of Family and Community Medicine; Founder of the non-profit Scituate Health Alliance (making this rural Rhode Island town the first community in the nation to provide primary medical and dental care to all its residents). ***/2014/ Dr. Fine's priorities for the Division of Community, Family Health & Equity (DCFHE) include***

the following areas: teen pregnancy prevention, universal adult immunization, obesity prevention, and compliance with federal CLAS standards //2014//. His strategies for addressing these areas include continuous quality improvement, public health department accreditation, primary care workforce development, and public/provider education.

As the recipient of the state's federal Title V MCH block grant funds, HEALTH's DCFHE plays the lead role in the state in addressing the MCH-related needs of children, including those with special health care needs (CSHCN) and their families in Rhode Island. The DCFHE has the capacity to promote and protect the health of all mothers and children, including CSHCN, in the state. The goal of the DCFHE is to achieve health equity for all Rhode Islanders, including pregnant women, mothers and children, through eliminating health disparities, assuring healthy child development, preventing and controlling disease, preventing disability, and working to make the environment healthy. The DCFHE uses a life course development approach that addresses the determinants of health as its framework for health planning. Like elsewhere in the nation, long established and emerging social, institutional, political, and economic conditions and policies continue to influence and shape MCH-related health outcomes in Rhode Island.

While the DCFHE has made significant progress in meeting its Title V national and state performance measures and Healthy People 2020 goals, disparities still exist. Therefore, proactive and applied public health strategies must continue to focus on all members of Rhode Island's state and local communities to eliminate health disparities in the state. It is through this collective work effort that DCFHE continues to offer quality programs, leverage limited resources, and works to assure that all Rhode Islanders achieve optimal health throughout the lifespan through a statewide system of services that are comprehensive, community-based, coordinated and family-centered. This approach is informed by the comprehensive MCH needs assessment, which serves as the foundation for Rhode Island's MCH infrastructure.

Housed in the DCFHE, the Office of Special Health Care Needs (OSHCN) is the designated state Title V MCH Office of CSHCN. The OSHCN is responsible for: 1) working to provide medical home enhancement for children and youth with special health care needs, including children with Autism Spectrum Disorder, through the Pediatric Practice Enhancement Project (PPEP), which ensures a coordinated system of care by providing trained parent consultants in pediatric primary and specialty care practices to assist families access community resources, assist physicians and families access specialty services, and identify barriers to coordinated care; 2) promoting health, wellness, and emergency preparedness for people with disabilities, including children, through surveillance professional development opportunities, and communities initiatives; a Special Needs Emergency Registry for people with special needs, chronic conditions, and disabilities in the event of an emergency; and a Traumatic Brain Injury (TBI) Registry and linkage program; and 3) assisting youth with chronic health conditions and disabilities transition to the adult system of primary and specialty care, education, employment, and insurance through its Adolescent Transition Program, which makes resources available for physicians, parents, and youth regarding the timeline and necessary components of transition that support self-determination.

The DCFHE and its MCH and CSHCN programs, along with all of the other programs administered by the DCFHE, work together to ensure a statewide system of services that reflect the principles of comprehensive, community-based, coordinated, family-centered care which are essential for effectively fostering and facilitating MCH activities. The DCFHE also values and works with the community as a core partner in MCH and works with the state's 39 cities and towns to assure that equity in MCH health becomes a 100% reality.

State Statutes Relevant to Title V

Section 23-13 of the Rhode Island General Laws (RIGL) provides the Department of Health with broad authority for administering Title V MCH services. Specifically, the statute "designates the state Department of Health as the state agency for administering in Rhode Island the provisions of Title V of the Social Security Act" relative to maternal and child health services and requires

the Department of Health to "administer a program of ambulatory health services for mothers and children and supervise the administration of those services included in the program, which are not directly administered by the department. The purposes of those programs are: to reduce maternal and infant mortality, reduce the incidence and prevalence of preventable diseases and disabling conditions among children, reduce the need for inpatient and long-term care services, increase the number of children (especially low income children) receiving immunization, health assessment, diagnostic, and treatment services, develop, extend, and improve ambulatory health services to locate, diagnose, care for, and rehabilitate children with disabling conditions, and otherwise preserve, protect, and promote the health of mothers and children. The director of health is authorized to promulgate rules and regulations that may be necessary to carry into effect the provisions of this section".

State Program Collaboration with Other State Agencies and Private Organizations, State Support for Communities, Coordination with Health Components of Community-Based Systems: The DCFHE works closely with other state agencies and private organizations to promote the healthy development of women, infants, and children, including CSHCN, in Rhode Island. It is important to point out that the state's human service departments are administered by the state's Executive Office of Health & Human Services (EOHHS).

The EOHHS was created to facilitate cooperation and coordination among the five state departments that administer Rhode Island's health and social service programs -- HEALTH, the Rhode Island Department of Human Services (including the Divisions of Elderly and Veterans Affairs), the Rhode Island Department of Education (RIDE), the Department of Children, Youth , and Families (DCYF), and the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH).Together, these departments affect the lives of virtually all Rhode Islanders, providing direct services and benefits to over 300,000 citizens while working to protect the overall health, safety and independence of all Rhode Islanders. HEALTH collaborations with these agencies are as follows:

RIDHS: The DCFHE has a Medicaid interagency agreement with DHS for several program/services - Lead Inspections, Environmental Health Administration, MCH Administration, Communicable Diseases, Primary Care Administration, and Nurse Assistant Registry (Division of EHSR). HEALTH also has Memoranda of Agreement with DHS to share data related to KIDSNET. Staff from HEALTH provide consultation and professional expertise to DHS in the areas of assessment, assurance, and policy development through formalized workgroups and program specific discussions to target outreach and program efforts.

The DCFHE also works collaboratively with DHS in the administration of the state's care coordination system for CYSHCN (CEDARR), the provision of services through the Early Intervention program, statewide access to screening and assessment for children with complex special health care needs, Viral Hepatitis B and C prevention efforts, and the administration of parent engagement to support clinical practices such as the Pediatric Practice Enhancement Project (PPEP). The DHS and the OSHCN collaborate on family engagement programs, parent leadership and stakeholder initiatives. The DCFHE and DHS also jointly manage and fund the Child Care Support Network. DHS is a full partner in the implementation of Successful Start, RI's Early Childhood Comprehensive Systems initiative. ***/2014/ DHS also serves on the Home Visiting Leadership Council //2014//.***

The DHS funds and certifies lead centers that provide non-medical case management to Medicaid-eligible children with elevated blood lead levels. The DCFHE provides quality assurance, establishes protocols, conducts reviews, offers training and sets minimum standards based on CDC guidance and benchmarks. DHS shares de-identified asthma-related Medicaid data with HEALTH's Asthma Control Program. /2013/ These data include Rite Care data. Medicaid staff participates as members of the Home Asthma Response Program, formerly known as the RI Asthma Emergency Department (ED) Diversion Pilot Project Advisory Committee.

RIDE: RIDE is a key partner in the implementation of RI's Early Childhood Comprehensive Systems Plan. HEALTH also has a seat on RI's Early Learning Council, which was appointed by the Governor and is charged with implementing specific goals around learning for children birth to five. /2013/ In 2011, RIDE received an Early Childhood Race to the Top grant, in which HEALTH is a key partner in both the management and implementation of grant activities. ***/2014/ RIDE also participates on the Home Visiting Leadership Council //2014//.***

Rhode Island was 1 of 9 states awarded a grant from the $500 million Race to the Top-Early Learning Challenge fund. Rhode Island was awarded $50 million over 4 years to improve early learning and developmental opportunities for Rhode Island's young children. There are 7 projects within Race to the Top focused on developing high quality and accountable programs, promoting early learning and development outcomes for children, building a great early childhood workforce, and measuring outcomes and progress. Five participating Rhode Island state agencies share responsibility for achieving grant outcomes including the lead state agency, Department of Elementary & Secondary Education (RIDE), Department of Human Services (DHS), Department of Children, Youth and Families (DCYF), Executive Offices of Health and Human Services (OHHS), and Department of Health (HEALTH).

HEALTH's focus is to provide support for primary-care providers in implementing a system of regular developmental screening (at 9, 18, & 30 months) consistent with the enhanced Early Periodic Screening, Diagnosis & Treatment (EPSDT) Schedule. In addition, HEALTH will support community-based, evidence-based interventions on early literacy, social emotional development, and family engagement in health settings.

HEALTH will provide technical assistance to primary health care providers to implement a system of standardized developmental screening. HEALTH staff will train providers on using the Ages and Stages Questionnaire-3 (ASQ-3). HEALTH will assist sites in setting up data collection systems. HEALTH is currently developing a system of electronic screening and electronic data capture with possible linkages to Electronic Health Records and/or KIDSNET. In addition, for children that screen out of the normal range, HEALTH will provide information about and link primary care providers with community-based referrals when available in the community.

Currently, developmental screening is being piloted at Hasbro Children's Hospital and St. Joseph Health Center through Project LAUNCH. Two child care centers (Beautiful Beginnings and Discovery Years) are manually entering developmental screening results into KIDSNET. KIDSNET is capturing scores, parental concerns and whether a child was referred, re-screened due to EPSDT schedule or re-screened due to a concern.

The Rhode Island Early Learning Council will facilitate the development or enhancement of high-quality systems of early childhood education and care, from birth to age 8, with the goal of improving school readiness and success in school. The Council will develop a state plan that will seek to align resources to support high quality early care and education services and to improve coordination and collaboration among multiple agencies, organizations and programs.

The work of the Council will build on the early care and education recommendations of the Successful Start Early Childhood System Plan, developed through a strategic planning process coordinated by HEALTH. The Successful Start strategic plan describes systems-building goals, objectives and implementation strategies that will improve and coordinate services, resulting in improved child and family outcomes.

Patient Centered Medical Homes (PCMH) -- KIDSNET will build on the strong foundation of the seven year old adult Medical Home collaborative, CSI RI. CSI has developed and sustained a strong multi-stakeholder collaboration, has implemented Medical Home contracting standards and quality metrics, and supported adult primary care practices to transform in to medical homes. The Medical home model has been shown to be equally effective in improving pediatric health outcomes, but has not been implemented within RI's multi-player initiative. With this initiative,

Executive Office of Health and Human Services (EOHHS) is particularly interested in addressing some specific high need populations, including children with special health care needs, children with developmental, educational or behavioral health problems, and children involved with the state's Department of Children, Youth, and Families (DCYF).

The OSHCN collaborates with RIDE on implementing and assuring access to special education through the Parent Information Network Resource Center, assisting families through the PPEP and providing workshops and technical assistance for families and school districts. RIDE and OSHCN partner on autism initiatives including the screening, diagnosis, and education of children and youth with autism spectrum disorders. The OSHCN is a member of the RIDE-led Transition Council established by state statute to coordinate the activities of state agencies and school districts for youth with disabilities transitioning from school to adult life; and RI's Special Education Advisory Council that oversees IDEA services in RI. RIDE continues to collaborate with DFCHE on Thrive, RI's coordinated school health program through maintenance of a joint website. RIDE, DCFHE, and HEALTH's Center for Data and Evaluation administer the Youth Risk Behavior Survey every other year in RI high school and middle schools and produce reports linking key health indicators and academic achievement along with reports that illustrate the disparities in health including gender, sexual orientation and disabilities.
HEALTH participated with RIDE in the development of Surveyworks, a new survey for students, parents and teachers related to factors involved in teaching and learning including health issues.

HEALTH has an ongoing collaboration with RIDE through the Vaccinate Before You Graduate Program (VBYG), a statewide school based influenza immunization program for students in grades K-12 and a dental screening program in select schools. DCFHE collaborated with RIDE to prioritize asbestos inspections in schools located in Environmental Justice Areas as defined by EPA. DCFHE participated in monthly meetings with the RI School Building Maintenance Director's Association, strengthening partnerships and communication regarding the Asbestos Hazardous Emergency Response Act requirements and responsibilities. The DCFHE provides technical assistance to RIDE in administering the Tools for Schools Program, which addresses indoor air quality and other environmental hazards. HEALTH also partners with RIDE in implementing sports concussion and injury prevention program. DCFHE partners with RIDE in the Child Opportunity Zone (COZ) initiative focused on parent and community support for student learning.

RIDCYF: The DCFHE is collaborating around data sharing via KIDSNET to better coordinate preventive health care for children in foster care. The DCFHE's First Connections Home Visiting Program is working with DCYF in the implementation of new regulations regarding screening young children with substantiated cases of child abuse/neglect for Early Intervention eligibility. First Connections nurse home visitors perform screening and serve as a liaison between DCYF and Early Intervention providers. DCYF is a full partner in the implementation of RI's Early Childhood Comprehensive Systems Plan. The DCFHE participates on the Children's Trust Fund, which administers the state's primary and secondary prevention of abuse and neglect. The Initiative for a Healthy Weight collaborates with DCYF, RIDE and DHS to improve nutrition and physical activity requirements for licensed childcare providers. ***/2014/ It also staffs a new Interagency Food and Nutrition Policy Advisory Council, which includes HEALTH, DEM, and DOA to identify barriers and solutions to create an equitable food system in Rhode Island //2014//.*** The Immunization Program partners with DCYF in educating child care workers and families about immunizations. DCFHE is also collaborating with DCYF to better understand the needs of youth in foster care especially as it relates to teen pregnancy prevention. ***/2014/ DCYF also participates on the Home Visiting Leadership Council //2014//.***

BHDDH: The DCFHE collaborates with BHDDH's Division of Substance Abuse (DSA) around training for Maternal, Infant, & Early Childhood Home Visiting (MIECHV) Program home visitors on substance abuse topics. The DCFHE collaborates with the DSA and DCYF though the Task Force on Premature Births to develop strategies for identifying pregnant women who misuse substances with the goal of decreasing preterm births while maintaining intact families. The

Tobacco Control Program collaborates with BHDDH around the enforcement of laws related to sales of tobacco products to minors. The Director of BHDDH has a seat on the DCFHE's Home Visiting Leadership Council (HVLC), the purpose of which is to create and align state policies for evidence-based home visiting programs, secure sustainable funding, support data collection and benchmark measurement, and identify unmet needs of families. ***/2014/ In addition, a representative of BHDDH has provided training on substance abuse to MIECHV-funded home visitors //2014//.*** A representative of the DSA has a seat on the Successful Start Steering Committee. The DCFHE's OSHCN coordinated transition services for youth with developmental disabilities and behavioral health diagnoses from pediatric to adult services in addition to participating on statewide advisory committees in behavioral health, developmental disabilities, and transition planning with BHDDH.

In addition to collaborating with the departments administered by the EOHHS, the DCFHE coordinates with the following other state departments:

The RI Department of Environmental Management (RIDEM): The DCFHE collaborates with DEM's Division of Agriculture in the promotion, support and monitoring of the WIC Farmers Market Nutrition Program. HEALTH and the RI DEM collaborate on reducing hazards from exterior lead paint and from asbestos. DCFHE worked in partnership with DEM, the RI National Guard and the EPA Region 1 Criminal Investigation Unit on several investigations regarding asbestos related compliance.

The RI Department of Transportation (RIDOT) has a cooperative agreement with DCFHE's Initiative for a Healthy Weight for improvements in community built environments to encourage active transportation. The Violence and Injury Prevention Program works with DOT, as part of the RI Traffic Safety Coalition to prevent motor vehicle injuries through passenger safety, graduated drivers licensing and driving under the influence policy work. It also works closely with RIDOT's Bicycle Safety Program.

The RI Department of Administration (RIDOA), Division of Statewide Planning (DSP): The DCFHE's Initiatives for a Healthy Weight Program, in partnership with the DSP, works with municipalities to incorporate elements of health in municipal comprehensive plans. ***/2014/ The DCFHE's Health & Climate Change Project also collaborates with the DSP to obtain stakeholder input in developing the RI Strategic Climate & Health Adaptation Plan //2014//.*** In addition to collaborating with state departments, the DCFHE collaborates with numerous private organizations including, but not limited to, the Rhode Island Chapter of the American Academy of Pediatrics (RI-AAP), the Rhode Island Chapter of the American College of Obstetricians and Gynecologists (RI-ACOG), The Warren Alpert Medical School at Brown University, Women & Infants Hospital of Rhode Island, the Safety Alliance Furthering Educational Resources, the RI Real Estate Investor Group, the RI Marine Trade Association, the RI Nursery and Landscape Association, the RI Manufacturers Association, four Lead Centers (St. Joseph Health Services, Blackstone Valley CAP, West Bay CAP, East Bay CAP, the Pawtucket Red Sox, the RI Lung Association, Apeiron Institute, RI Builders Association, RI Community Action Programs, Association of School Building Maintenance Directors, Green & Healthy Housing Initiative, Rhode Island Keep Space, RI Hospitals for a Healthy Environment, DCYF-licensed child care providers in center-based and home programs, the RI Training School, Planned Parenthood of Rhode Island, the Primary Care Physician Advisory Committee (PCPAC), the Children's Neurodevelopment Center at Hasbro Children's Hospital (CNDC), the WIHRI RI Hearing Screening Assessment Program (RIHAP), the RIHAP Hearing Screening & Follow-Up Committee, RI Family Voices, school and child care providers, the RI Oral Health Commission, the RI Parent Information Network (RIPIN), the RI Task Force on Premature Births, the Brain Injury Association of RI, Quality Partners, Inc., the RI Health Center Association, the American Lung Association, the RI Breastfeeding Coalition, the RI Chronic Care Collaborative, the RI Asthma Control Coalition, the Asthma Regional Council (ARC), the Community Health Worker Association of RI (CHWARI), ***/2014/ and Thrive By Five, a subcommittee of Newport Partnership for Children //2014//.***

State Support for Communities

DCFHE supports breastfeeding training of WIC nutritionists, WIC Peer Counselors and community educators, by offering training as Certified Lactation Consultants (CLC) and International Board Certified Lactation Consultants (IBCLC).

Ready to Learn Providence (R2LP) supports the Providence Plan's strategic planning initiative to increase utilization of MCH services among young families, including CYSHCN living in the city of Providence. The DCFHE continues to work with the Providence Plan to develop a statewide housing database to target unhealthy housing in the core cities and to link lead poisoning data to elementary school test scores. ***/2014/ The Providence Plan is incorporating asthma related data into healthy housing and climate elated analysis //2014//.***

Child Care Support Network supports healthy child care environments through contracts to local community agencies. These agencies have staff that conduct technical assistance to childcare providers to promote children's mental health and healthy development. The Successful Start Early Childhood Comprehensive Systems initiative supports a plan with specific goals and objectives around developing an overall early childhood system which includes five core components of the state's existing early childhood system including medical homes, social and emotional development, child care, parenting education, and family support for all children. Progress has been made on all of the goals within the plan and after four years of implementation, in 2011/2012, the plan was updated and is in the process of being approved. A transition advisory group to include adolescent systems development has produced a strategic plan for adolescent health, a needs assessment of adolescent access to preventive care services and informed teen pregnancy prevention efforts.

The Title X Family Planning Program collaborates with ***/2014/ seven federally qualified community health centers, Planned Parenthood of Southeastern New England, and the Women's Division of the Rhode Island Department of Corrections to provide affordable, confidential contraceptive and preventive health services to culturally diverse, primarily low-income men, women, and adolescents. Through a collaborative effort with community partners and internal programs, the Family Planning Program led the development of a statewide strategic plan to address preconception health. Implementation will begin in spring 2013 //2014//.***

KIDSNET: The Asthma Control Program added an asthma component to KIDSNET to allow providers in the Blackstone Valley Community and St. Joseph Health Centers to refer families to the Breathe Easy at Home Project in the cities of Pawtucket and Providence. ***/2014/ The City of Woonsocket and Thundermist Community Health Center were added as participants of the Breathe Easy At Home Project //2014//.***

Rhode Island Chronic Care Collaborative (RICCC): ***/2014/ The DCFHE, Chronic Care and Disease Management Team continues to contract with 16 RICC health centers that serve high risk minority populations to improve asthma and diabetes care to women and children using the Care Model & Model of Improvement. One hospital-based health center no longer participates due to significant staffing changes //2014//.***

RI Asthma Control Coalition: The RI Asthma Control Program continues to work closely with the Coalition to reduce asthma hospitalization and ED visit rates. The Asthma in Schools and Clinical Care Committees target youth through addressing the environmental health of schools, communication with school nurse teachers, and improvement in asthma care among primary care providers. The Advocacy and Policy Committee convened for the first time on March 2nd to address disparities in pediatric asthma. ***/2014/ The RI Asthma Control Coalition works closely with the RI Asthma Control Program to reduce asthma hospitalization and ED visit rates. The Asthma in Schools Committee targets youth by addressing the environmental health***

of schools, communication with school nurse teachers, and improvements in asthma care among primary care providers through the controlling Asthma in Schools Effectively (CASE) //2014//.

RI Asthma Emergency Department (ED) Diversion Pilot Project Advisory Committee: The RI Asthma Control Program convenes RI Asthma ED Diversion Pilot Project Advisory Committee guide efforts designed to reduce asthma ED visits by providing home visits to children who enter the ED or are admitted to Hasbro due to asthma. Home visits include an educational and environmental component. Hasbro Children's Hospital, St. Joseph Health Center, and RI Parent Information Network are partners in this effort.

The Home Asthma Response Program (HARP) Advisory Committee: The RI Asthma Control Program convenes the Home Asthma Response Program (HARP) Advisory Committee which guides efforts to reduce asthma ED visits by providing home visits to children who enter the ED or are admitted due to asthma. Home visits include an educational and environmental component. Hasbro Children's Hospital, St. Joseph Health Center, and RI Parent Information Network are partners in this effort. 29 patients completed the program in Phase 1. ***/2014/ 70 additional patients were recruited in Phase 2 which ended September 2012. 53 patients completed phase 2 of the Home Asthma Response Program. Preliminary results of Phase I show a significant reduction in asthma ED visits among the 29 participating patients //2014//.***

The Diabetes Prevention and Control Program (DPCP) will fund a follow-up demonstration pilot project to ensure that women who have been diagnosed with gestational diabetes receive oral glucose testing and referrals to appropriate services for diabetes or pre-diabetes care. ***/2014/This Pilot Project, funded by Title V and the Diabetes Prevention & Control Program in HEALTH ended July 30, 2012. Project data demonstrated that intensive intervention consisting if arranging testing appointments, tracking test completion, providing reminders for attendance and rescheduling missed appointments led to improved post partum glucose tolerance testing rates from 43.1% to 59.4%. 100% of the women diagnosed with pre-diabetes, or at track for diabetes, were referred to the YMCA's Diabetes Prevention Program //2014//.***

The DCFHE supports the implementation of Teen Outreach Program, an evidence based youth development program in eight sites in Rhode Island including the four core cities.

/2014/ The DCFHE supports evidence-based chronic condition self-management health promotion activities to vulnerable populations including people with disabilities and racial and ethnic minorities. Community-based agencies involving the initiative are Ocean State Center for Independent Living, PARI Independent Living Center, Federal Hill House, Southeast Asian Economic Development Center, Woodlawn Community Center, and Dorcas International Institute.

The DCFHE has convened a new Health Collaborative Network of RI state and local stakeholders from multiple coalitions and interest groups doing strategic thinking and implementing to support communities in their efforts to prevent and control chronic conditions and to promote healthy living. Communities are also supported via a new Healthy Places Learning Collaborative, which provides web-based resources and tools, with in-person TA, to help communities address health equity and disparities //2014//.

Coordination with Health Components of Community-Based Systems

HEALTH provides all recommended childhood vaccines to providers at no charge via a universal vaccine purchase and distribution system. The program coordinates with providers, community based hospitals and health centers to offer free vaccines to uninsured children. The WIC Program is co-located within local Community Health Centers and Hospitals providing direct referrals and increased access to services including medical care, dental care, social services, lead screening

and immunizations.

The Perinatal and Early Childhood Team coordinates with a number of existing systems relevant to children's health care. Watch Me Grow RI, the First Connections Home Visiting Program, and the Child Care Support Network all coordinate with SCHIP, Early Intervention, the system of Community Mental Health Centers, and the Child Care Subsidy system. The Newborn Screening program coordinates with the birthing hospitals, ***/2014/ the University of Massachusetts State Laboratory, RI Hospital, midwives, the Birth Defects Program, the Rhode Island Hearing Assessment Program, the Commission for the Deaf and Hard of Hearing, Early Intervention, the School for the Deaf, Orchard Farm School, pediatric audiologists, the Rhode Island Parent Information Network, and the First Connections Home Visiting Program to track children in need of follow up //2014//.*** The Healthy Housing and Lead Poisoning Prevention Program also coordinates with Medicaid, the states system of Lead Centers and the two lead clinics in the state that provide medical treatment for significantly lead poisoned children.

The First Connections Home Visiting Program contracts with four community based agencies to conduct home visits to almost 25% of families with newborns who have specific risk profiles created from information collected at birthing hospitals providing general parenting information, conducting home assessments, and educating parents about infant care, and linking families to appropriate resources. Home visitors also serve as the follow-up staff for the Newborn Screening, Lead Poisoning Prevention, and Immunization Programs. First Connections is an active contributor to the Child Find system for the Early Intervention program.

The MIECHV Program provides comprehensive evidence-based home visiting services to pregnant women and families with children up to age three. MIECHV programs include Nurse Family Partnership, Healthy Families America, and Parents as Teachers. MIECHV programs are required to participate on MIECHV Community Coalitions, which were established to coordinate MIECHV activities and to identify unmet needs on the local level. The Community Coalitions are composed of a wide array of local community agencies and advocates from a variety of disciplines including, but not limited to, medical care, housing, substance abuse, mental health, education, social services, etc . ***/2014/ MIECHV agencies also participate in local Implementation Teams (LITs) to coordinate referrals and direct services //2014//.*** The MIECHV Program has also established a Home Visiting Leadership Council (HVLC) to create and align policies for MCH home visiting programs in the state.

Watch Me Grow RI is a program that provides support to pediatric primary care providers and child care providers to implement developmental screening within community-based settings. WMGRI also provides technical assistance around understanding community services and how to refer/link to these services. As a result of the AAP recommendation around autism specific screening in addition to standardized developmental screening, WMGRI and the OSHCN provides technical assistance on standardized measures of development.

/2014/ The Oral Health Program collaborated with and supported four school-based dental programs from 2011-2012. During that time, dental sealant application was increased for children in high risk schools (those with >50% students eligible for free/reduced school meals //2014//.

The DCFHE convenes a Healthy Housing Collaborative, a statewide collaborative of agencies and individuals, designed to help move communities towards a more comprehensive approach to healthy housing practices and encourage landlords to use the web based HomeLocatorRI.net to promote their rental units with healthy housing characteristics for families in need. RI KidsCount, the Annie E. Casey Foundation, and DCFHE launched the first 'health and house' indicator in the 2009 edition of the KidsCount Fact Book. ***/2014/ The DCFHE continues to report indicators of healthy housing in the most recent versions of the Fact Book //2014//.***

Coordination of Health Services with Other Services at the Community Level

During a WIC Certification appointment clients are assessed for any needs on an individual basis. Appropriate referrals are made (i.e. smoking cessation, housing, fuel assistance, food pantries, etc).

First Connections, ***/2014/ Healthy Families America, Nurse Family Partnership, and Parents As Teachers programs //2014//*** coordinate with the system of pediatric primary care to accept referrals, coordinate information exchange and make referrals to many diverse community programs ***/2014/ and establish medical homes //2014//.*** The Teen Outreach Program, an evidence based youth development curriculum is included in the services offered.

The Newborn Screening Program coordinates with community based and hospital based programs, which address the needs of families with children who have specific disabilities and disorders. The Newborn Screening Program provides universal newborn screening and follow-up for 29 metabolic, endocrine, and blood disorders along with hearing screening and developmental risk assessments for newborns. Implementation of a newborn developmental risk module is integrated with a new electronic birth certificate system.

OSHCN and parent consultants worked with parents to develop "medical passports" which contain information about services for CYSHCN and their families in RI. The DCFHE works with the New England Regional Genetics Group (NERGG) for technical assistance in implementing HEALTH's statewide genetics plan focusing on access to genetics services.

The Pediatric Practice Enhancement Project (PPEP) is a medical home enhancement for children and youth with special healthcare needs. PPEP ensures a coordinated system of care for children and youth with special needs and their families by placing trained peer resource specialists in 24 pediatric primary and specialty care practices to assist families in accessing community resources and to identify barriers to coordinated care.

The Birth Defects Program continues to work to assure that children with birth defects are identified and that they and their families receive appropriate services on a timely basis. The Program's activities focus on case ascertainment, service assurance, prevention, and information dissemination. The RI Birth Defects Advisory Council provides guidance in all of these areas.

/2014/ SSDI activities include: 1) traning and documentation of data sources for the data resources for the Department of Human Services data warehouse; 2) collection of enrollment data from health insurers, including all RIteCare enrollees; 3) update of hosital discharge date recorded in KIDSNET from th ehospital discherge data set; 4) devlopment of life cource performance measures; 5) address standardization for KIDSNET to facilitate GIS analysis; 6) production of a KIDSNET data book that will map selected MCH data; 7) development of MCH data stories and analyses in the RIDE data hub; and ongoing and ad hoc support of MCH data needs//2014//.

The Healthy Housing and Lead Poisoning Program refers children who are significantly lead poisoned to a network of lead centers that deliver direct services in the form of non-medical case management services and family support, educational information, and referrals . The DCFHE supports a clinic offering lead screening testing free of charge for children who are uninsured in one of the major pediatric hospitals in Providence.

/2014/ A Community Health Network Centralized Referral System ensures referrals of women identified with a tobacco risk to Rhode Island's Helpline for Smokers. Health professionals can also refer patients to the Quitline through a fax referral system called Quitworks-RI //2014//.

The Initiative for a Healthy Weight and KIDSNET continue to pilot a program to collect BMIs from

pediatric practices, and to train providers in how to use information and counsel families to reduce childhood obesity.

The Asthma Control Program contracts with RICCC health centers to improve quality of asthma care. In addition, the RIACP is building capacity to support environmental interventions for children with asthma that frequent the hospital and ED due to asthma. Women with gestational diabetes who are diagnosed with pre-diabetes or at risk for diabetes are referred to an evidenced-based diabetes prevention program provided by the YMCA. ***/2014/ The Asthma Control Program has integrated the Home Asthma Response Program and Breathe Easy at home Project into one more RICC health center, for a total of three, to provide resources to providers and patients to reduce triggers and improve outcomes related to asthma //2014//.***

The Statewide Breastfeeding Coalition has had an impact on breastfeeding support both in the community and at the legislative level. WIC collaborates with Women & Infants Hospital to support breastfeeding in the Neonatal Intensive Care Unit and throughout the hospital for WIC eligible clients. The WIC Breastfeeding Coordinator works closely with the staff of the Initiative for a Healthy Weight to promote Breastfeeding in the workplace and to promote baby friendly hospitals in Rhodde Island.

The Successful Start Steering Committee is comprised of approximately 20 community members and state agency representatives. This committee is responsible for helping to implement RI's early childhood comprehensive systems plan. A Successful Start Adolescent Transition Advisory Group was established in 2010 to continue to develop systems to support school aged children and adolescents.

The Women's Health Advisory Committee advises the HEALTH & the DCFHE's Office of Women's Health on statewide priorities and policies to enable women to live to their optimal level by promoting a gender-informed, coordinated, comprehensive, primary prevention approach to women's health across the lifespan. Work is targeted to eliminate health disparities across all dimensions of age, ability, geography, race, ethnicity, sexual orientation, economics, and education.

A Commission on Health Advocacy and Equity was established in June 2011 to coordinate the expertise and experience of the state's health and human services systems, housing, transportation, education, environment, community development and labor systems in developing a sustainable and comprehensive health equity plan. The commission will review and evaluate progress in reducing health disparities and implementing policies and programs to improve health outcomes of minorities across all settings.

Rhode Island is a 1914 A state (i.e. all children participating in the Supplemental Security Income program receive Medicaid benefits which includes rehabilitative services). The DCFHE participates in the Rhodes to Independence Medicaid Infrastructure Steering Committee, the Global Medicaid Waiver State Implementation Team, and the Family Voices Leadership Team to ensure a safety net for children eligible for SSI and their families. The Teams include the Departments of Health, Education, Human Services, Children, Youth and Families along with the RI Parent Information Network, RI Family Voices, and Hasbro Children's Hospital.

The DCFHE and its OCSHCN facilitates the development of community-based systems of services for CSHCN and their families, which focuses mainly on infrastructure building activities including: leadership for the special needs service delivery system, especially as it relates to access and quality of pediatric specialty services, educating children with special needs, family engagement and secondary transition. DCFHE invests in the special needs infrastructure through parent support and empowerment opportunities and the provision of quality assurance through a special needs leadership council.

C. Organizational Structure

Organizational Structure

/2013/ As previously noted, the Rhode Island Department of Health's (HEALTH's) DCFHE plays the lead role in the state in addressing the MCH-related needs of children, including those with special health care needs (CSHCN) and their families in Rhode Island. HEALTH is located within the state Executive Office of Health and Human Services (EOHHS), a cabinet agency that directly reports to the Governor. The state's Title V Program, including the CSHCN program, are housed within the DCFHE. Section 23-13 of the Rhode Island General Laws provides HEALTH with broad authority for administering Title V MCH services, including services for CSHCN, in the state. ***/2014/ In accordance with the Title V grant guidance, an organizational chart has been included as a part of the FY2014 application as an attachment to this section (See Attachment IV) //2014//.***

The goal of the DCFHE is to achieve health equity for all Rhode Islanders, through eliminating health disparities, assuring healthy child development, preventing and controlling disease, preventing disability, and working to make the environment healthy. The DCFHE uses a life course development approach that addresses the determinants of health as its framework for health planning, including MCH planning. The DCFHE is organized into the Office of the Executive Director and six (6) Teams as follows:

The Office of the Executive Director (OED) is responsible for providing leadership, vision, communication, and direction to the administrative staff, team leads, and support staff across all six (6) teams. Proactive and applied public health strategies focus on all members of the community to eliminate health disparities throughout Rhode Island. As a division team, integration between public health programs, including social, political, and economic policies that determine health outcomes, plays a key role in improving the lives of all Rhode Islanders, including pregnant women, mothers, and children. It is through this collective work that the DCFHE offers quality programs and continues to assure that all Rhode Islanders, including mothers and children, will receive optimal health throughout the lifespan.

On the leadership level, the OED includes an Executive Director, a Medical Director, ***/2014/ an Interdepartmental Project Manager //2014//***, and a Chief of Program Operations. ***/2014/ A new Maternal & Child Health (MCH) Specialist position is housed in the OED. This position is currently vacant. This position will be responsible for coordinating all MCH activities including, but not limited to, the preparation of the Title V application //2014//.*** It is the responsibility of the OED to assure that maternal and child health initiatives taking place internally within the DCFHE and those taking place externally to the DCFHE work together to ensure a system of care for mothers and children, including CSHCN, that is coordinated, comprehensive, and community-based.

The Health Disparities and Access to Care Team is responsible for assuring equitable systems, empowering communities, and building capacity to promote access to comprehensive high quality services that are responsive to the needs of Rhode Island's diverse populations so that they achieve their optimal state of health. ***/2014/ The Team includes three (3) offices: Special Health Care Needs, Minority Health & Minority Health Promotion, and Primary Care and Rural Health //2014//.*** The Team is responsible for managing the following initiatives:

- Refugee Health Program: works to ensure that refuges and asylees enter into a comprehensive system of care;
- Minority Health Programs: work to eliminate racial and ethnic disparities to assure equal access to high quality health services;
- CLAS Initiative: works to ensure the implementation of federal CLAS standards in all health care programs that receive federal funding;
- Family & Peer Resource Specialist Program: works to bring the perspectives of parents, youth, and consumers into policy development and medical home implementation;
- Pediatric Practice Enhancement Project (PPEP): enhances medical homes through peer-

assisted care coordination for children and youth with special health care needs (PPEP is a nationally recognized best practice initiative);

* ***/2014/ Pediatric Specialty Services: works to ensure access to specialty assessment and treatment for CSHCN //2014//;***

- Disability & Health Program: works to promote health, wellness, health care accessibility, and emergency preparedness for people with disabilities, including CSHCN;
- Adolescent Transition: works to assist youth with SHCN transition to the adult systems of primary and specialty care, education, employment, and insurance;

* ***/2014/ Dare to Dream Student Leadership Development Program: provides opportunities for youth with disabilities to learn self-determination and leadership skills from their peers;***

* ***Youth Advisory Committee; advises the OCSHCN at the DCFHE at large on youth engagement, youth-led initiatives, and student empowerment models //2014//;***

- Women's Health: works to eliminate health status disparities for Rhode Island women;
- Primary Care and Rural Health: works to increase access to high quality, comprehensive, coordinated, culturally appropriate care for underserved Rhode Islanders through needs assessment, promotion of the health care safety net, workforce development, collaboration with health system stakeholders, and community capacity building; and
- Hospital Charity Care: works to educate health care providers and patients about state regulations that require non-profit hospitals to provide free and discounted care to the uninsured poor.

The Healthy Homes and Environment Team is responsible for protecting the health and safety of children, workers, and the general public by identifying and decreasing environmental hazards. ***/2014/ The Team has four (4) areas: Healthy Workplaces/Work Practices, Healthy Housing, Healthy Communities, and Climate Change. The Team is responsible for managing the following initiatives //2014//:***

- Indoor Air Quality: Asbestos Control Program: works to protect the public from exposures to carcinogenic airborne asbestos through hazard assessment and abatement;
- ***/2014/ Healthy Housing & Lead Poisoning Prevention Program: works to support statewide screening efforts and surveillance and to build strategic alliances for healthy housing including lead-safe" and "smoke-free" housing //2014//;***
- Environmental Professional Oversight: works to meet all US Environmental Protection Agency (EPA) requirements for training, licensure, and certification of environmental professionals;
- OSHA Consultation Program: works to provide safety and health consultation services to small and medium size private businesses; and
- Indoor Air Quality: Radon Control Program: works to protect the public from lung cancer due to radon exposure.

* ***/2014/ Health & Climate Change Project: works to develop an understanding of how climate change will directly and indirectly alter human health risks in Rhode Island, especially for those most vulnerable to the projected adverse health effects. The final RI Strategic Climate and Adaptation Plan will provide decision-makers, members of the general population, and Rhode Island residents with recommendations for addressing climate change impacts //2014//.***

The Chronic Care and Disease Management Team is responsible for reducing the incidence, burden, and associated risk factors related to asthma, heart disease and stroke, diabetes, and cancer to improve health outcomes. ***/2014/ The Team has seven (7) areas: Diabetes Control, Asthma Control, Cancer Control, Heart Disease & Stroke Prevention, Living Well Rhode Island, Arthritis, and Women's Cancer Screening. The Team is responsible for managing the following initiatives //2014//:***

- The Asthma Control Program: works to increase access to quality health care, education, community resources and services for Rhode Islanders with asthma;
- Heart Disease and Stroke Prevention Program: works to eliminate disease by addressing systems changes including behavior change and enhancing access to care;

- Diabetes Prevention & Control Program: works to coordinate the statewide diabetes health system composed of over 700 agencies and individuals;
- Comprehensive Cancer Control Program: works to develop, implement, and maintain a statewide coalition representing a broad base of state and community cancer interests;
- Women's Cancer Screening Program: works to reduce the burden of breast and cervical cancer among low-income women;
- ***/2014/ Arthritis Program: works to embed arthritis-appropriate evidence-based interventions into multi-site service delivery systems and conduct arthritis-related surveillance; and***
- ***Living Well Rhode Island: works to increase the number of older and disabled adults with chronic conditions who complete evidence-based self-management education programs in sustainable services systems //2014//.***

The Health Promotion and Wellness Team is responsible for supporting healthy living through the life course. ***/2014/ The Team has three (3) areas: Tobacco Control, Initiative for a Healthy Weight, and Safe RI/Violence Injury Prevention. The Team is responsible for managing the following initiatives:***

- ***Tobacco Control Program: works to make it hard for people to start using and to continue to use tobacco by 1) preventing initiation of tobacco use among young people, 2) eliminating nonsmokers' exposure to secondhand smoke, 3) promoting quitting among adults and young people, and 4) eliminating tobacco-related disparities;***
- ***Initiative for a Healthy Weight: works to prevent and control obesity and to support and reinforce healthy behaviors by increasing opportunities for physical activity and improved nutrition at state and local levels; and***
- ***Safe RI -- Violence and Injury Prevention Program: provides data and technical assistance to partners to implement effective injury prevention programs in the areas of prescription drug overdose, motor vehicle crashes, elder falls, and youth suicide //2014//.***

The Perinatal and Early Childhood Health Team is responsible for supporting healthy birth outcomes, positive early childhood development, and school readiness in preparation for a healthy, productive adulthood by providing and assuring mothers and children access to quality MCH services. ***/2014/ The Team has six (6) areas: WIC, Adolescent Health, Newborn Screening & follow-Up, successful Start and RI Launch, Race to the Top, and Home Visiting. The Team is responsible for the following initiatives //2014//:***

- WIC: works to provide healthy foods, nutrition assessment, and nutrition education for optimal nutrition during critical stages of growth and development and breastfeeding support and promotion;
- Newborn Screening and Follow-Up: works to screen all newborns for metabolic, endocrine, hemoglobin, hearing, and developmental risk factors;
- Early Childhood Development Screening and Follow-Up: works to increase the number of children birth to 8 receiving developmental and behavioral screenings consistent with current AAP recommendations in primary care, child care, and other settings and to provide comprehensive home visiting services -- including First Connections home visiting services for at risk children birth to 3 and evidence-based MCHB MIECHV services for pregnant women and at risk children birth to 3;
- Successful Start: works to maintain an early childhood system building initiative that focuses on five system components -- Medical Homes, Social & Emotional Health, Early Care and Education, Parent Education, and Family Support);
- RI-Launch: works to place mental health clinicians in pediatric primary care practices and child care centers to address the needs of children birth to 8 years old;
- Adolescent Health: works to promote healthy adolescent development through statewide systems, policies, and initiatives as well as targeted interventions to address health risks in high need communities; and, more recently
- Race to the Top Early Learning Challenge: works with other state agencies to improve early learning and development opportunities for young children (the Team will support 90 pediatric practices to implement standardized developmental screening and will also provide

supports to primary care providers to address the needs of families in their practice that arise as a result of developmental screening)

The Preventive Services and Community Practices Team is responsible for improving the quality of preventive and community services by increasing access and availability to vulnerable populations. ***/2014/ The Team has three (3) areas: Immunization, Oral Health, and Family Planning. The Team is responsible for the following initiatives //2014//:***

- Immunization: works to prevent and control vaccine preventable disease by maximizing the number of adults and children who are immunized;
- Oral Health Program: works to prevent oral health disease by increasing access to and utilization of preventive interventions including dental sealants for children and appropriate water fluoridation for all Rhode Islanders ***/2014/ and works to increase access to high quality, comprehensive, coordinated, culturally appropriate oral health/dental care for underserved Rhode Islanders through needs assessment, promotion of the health safety net, workforce development, collaboration with health system stakeholders, and community capacity building //2014//***; and
- Family Planning Program: works to provide affordable Title X family planning services, including comprehensive preconception care services, to low income men, women, and adolescents.

The WIC Program was transferred to the Rhode Island Department of Human Services (RIDHS) in 2011. It is still housed in the DCFHE at HEALTH. The Ryan White HIV Care Program was transferred to the Executive Office of Health & Human Services (EOHHS) effective July 1, 2012. There are plans for the program to physically move to the EOHHS sometime in the near future //2013//. ***/2014/ The HIV Prevention Program was transferred to HEALTH's Division of Infectious Diseases in 2013 //2014//.***

An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

D. Other MCH Capacity

/2014/ There are 105 Full-Time Equivalents (FTEs) who work in the DCFHE as state employees. This number includes staff that provides planning, implementation, evaluation, and data analysis. In addition, the Division's staffing configuration includes 8 consultants (which include 2 CDC Prevention Public Health Consultants), and 33 parent consultants (9 of who work directly in the Department and 24 of whom work in community settings). The USDA WIC Program budget, including staffing, were transferred to the state Department of Human Services, but the 11 filled WIC FTE positions are currently located in the DCFHE //2014//.

Parent consultants are culturally diverse /2013/ parents with experience accessing MCH services

//2013// and are assigned to DCFHE programs based on the program's need for parent participation and the parent consultant's experience with the program. Parent consultants are assigned to the WIC Program, the Immunization Program, the Birth Defects Program (based in the Center for Health Data and Analysis), and the OSHCN. Many of the parent consultants are parents of CYSHCN and all are consumers of DCFHE programs or have been in the last three years. Parent consultants are full partners in policymaking, outreach, and program quality assurance and evaluation.

In addition to these parent consultants, the DCFHE also manages the Pediatric Practice Enhancement Project (PPEP), which has placed 24 resource specialists in pediatric practices serving high volumes of CYSHCN throughout the state. There are 12 pediatric primary sites, 10 specialty care sites and 2 sites outside the medical community. The pediatric primary care sites include hospital-based primary care clinics, health centers, private physician offices, and private physician group practices in geographic locations throughout the state serving ethnically, culturally, linguistically, and geographically diverse populations. Specialty care sites include multi-disciplinary evaluation, intensive clinical, disability specific, special intervention, and dental. The additional two non-medical sites include a correction department and a social service agency.

All DCFHE staff, with the exception of PPEP resource specialists, is centrally located at the RI Department of Health in Providence, RI. Brief biographies of senior level management staff are included below.

Executive Director's Office

/2013/ Ana Novais, MA, is the Executive Director of the DCFHE and, in this capacity; she provides leadership for the Division and its programming. She has been employed HEALTH since 1998 and has served as Associate Director of Health, Lead for the Center for Health Equity and Wellness, and Chief of the Office of Minority Health. Previously, she worked as the Director of Community Services for a multi-service organization serving culturally diverse families and children. She received her Masters Degree in Psychology from the Universite Catholique de Louvain in Belgium.

Peter Simon, MD, MPH, is the Medical Director of the DCFHE. Dr. Simon is a graduate of Cornell University and the State University of New York, Upstate Medical School in Syracuse. He received his MPH from Johns Hopkins University in 1976. He is certified by the American Board of Preventive Medicine and the American Board of Pediatrics. After working as a private pediatrician in Pawtucket, RI, he joined HEALTH as a Medical Epidemiologist in 1984 after having served for seven years as a Consultant Medical Epidemiologist for the state's Immunization and Childhood Lead Poisoning Prevention Programs. Dr. Simon continues to see pediatric patients at the Providence Community Health Centers and volunteers at the Hospital Albert Schweitzer in rural Haiti.

Carol Hall-Walker, has served as the DCFHE's ***/2014/ Interdepartmental Project Director since 2006 //2014//***. She is responsible for strategic planning related to MCH, management oversight of the six teams to enhance and expand integration that include the programs directly receiving Title V support, communications and public engagement in partnership with DCFHE programs. Ms. Hall-Walker joined the staff of the Rhode Island Department of Health (RIDH) in 1993, as Communications Coordinator of the Tobacco Control Program. In 1999, she was named the Communications Manager of HEALTH's Division of Disease Prevention and Control, and in 2005, she was the Communications Manager for HEALTH's Center for Public Health Communications. Previously, she worked in direct services and advocacy related to public health issues.

Perinatal & Early Childhood Health Team

Blythe Berger is currently the Team Lead of the DCFHE's Perinatal and Early Childhood Health Team. She is responsible for all activities relevant to Perinatal and Early Childhood Health for the

State Health department, including WIC, Newborn Screening, Home Visiting, Early Childhood Screening and Follow-up, Adolescent Health, and Child Care Quality projects.

Chronic Care & Disease Management Team

Dona Goldman, RN, MPH, has served as the Team Lead for the Chronic Care and Disease Management Team in the DCFHE since 2006. In this capacity, Ms. Goldman provides oversight of Women's Cancer Screening, comprehensive Cancer, Diabetes, Colorectal Cancer, Asthma, Heart Disease & Stroke Prevention, ***/2014/ Arthritis //2014//*** and the Chronic Disease Self-Management Program.

Health Disparities & Access to Care Team

/2014/ The position of Team Lead for the Health Disparities & Access to Care Team in the DCFHE is currently vacant. The position has been posted and candidates for the position are presently being interviewed.

Deborah Garneau is the Acting Team Lead for the Health Disparities & Access to Care Team and is the Chief of the Office of Special Health Care Needs (OSHCN) at the Rhode Island Department of Health. In this position she is responsible for the supervision, management, and leadership of the Office of Primary Care, the Office of Minority Health, and OSHCN's three program areas including Pediatric Specialty Services, Disability and Health, and Family Support and Empowerment //2014//. Ms. Garneau served as a mental health clinician and administrator with at-risk children and their families prior to state service.

Health Promotion & Wellness Team

Jan Shedd, EdM, is the Team Lead of the Health Promotion & Wellness Team. Jan Shedd has been employed by HEALTH since 1980 and in this capacity; she has worked in community health promotion and WIC, and has served as Manager of Rhode Island's Title X Family Planning Program and the RI State Adolescent Health Coordinator. Ms. Shedd has an Education Masters in Community Health Education from Oregon State University.

Preventive Services and Community Practices Team

Patricia Raymond, RN, MPH, has served as the Team Lead of the DCFHE's Preventive Services and Community Practices Team since 2007. She has been employed by HEALTH since 1997, where she served as a Public Health Nurse with HEALTH's Children's Preventive Services Program. Ms. Raymond has a Masters of Public Health from the University of Massachusetts Amherst, School of Public Health and Health Sciences and a Bachelor of Science in Nursing from Rhode Island College.

Healthy Homes and Environment Team

Robert R. Vanderslice, PhD, has served as the Team Lead of the Healthy Homes and Environment Team since 2007. Dr. Vanderslice has been employed with HEALTH since 1992. Prior to assuming his current position, he served as Chief and Toxicologist of HEALTH's Office of Environmental Health Risk Assessment; Environmental Scientist for the US Department of Housing & Urban Development, Office of Healthy Housing and Lead Hazard Control; and Toxicologist, US Environmental Protection Agency. Dr. Vanderslice received both his Masters Degree and PhD in Toxicology from North Carolina State University.

Center for Health Data and Analysis

Sam Viner-Brown, SM, has served as Chief of HEALTH's Center for Health Data and Analysis since 2008. In this capacity, Ms. Viner-Brown is responsible for, among other things, all Title V MCH data, KIDSNET, and PRAMS. She served as the DCFHE's Chief of Data & Evaluation from

1991-2008. Ms Viner-Brown graduated from the Harvard University School of Public Health, where she concentrated in Health Policy and Management.

Ellen Amore, MS, has served as the Program Manager of HEALTH's KIDSNET since 2007. Ms. Amore received her Masters Degree from the Harvard School of Public Health, where her field of study was Maternal and Child Health. She has been employed by HEALTH since 1995 and in this capacity she served as the Program Manager for the Home Visiting Program and the Program Manager for the Newborn Screening Program prior to becoming the Program Manager for KIDSNET.

Other available information about the non-governmental health care workforce, which includes the non-governmental MCH workforce, shed some light on the state's MCH workforce capacity. In 2008, the number of physicians per 10,000 population in Rhode Island was 34.5, which ranked the state higher than the nation (25.7% per 10,000 population) and the second highest of the six New England states after Massachusetts (39.7 per 10,000 population). In contrast, the number of physicians per 10,000 population in Connecticut was 33.5, in Vermont it was 33.3, in Maine it was 28.2, and in New Hampshire it was 26.4.

In 2010, the number of physician assistants per 100,000 population in Rhode Island was 27, which ranked the state equal to the national rate but the lowest in New England. In contrast, the number of physician assistants per 100,000 population in Maine was 49, in Vermont and Connecticut it was 47, in New Hampshire it was 43, and in Massachusetts it was 34.

In 2011, the number of nurse practitioners per 100,000 population in Rhode Island was 66, which ranked the state higher than the nation (58 per 100,000 population) but the lowest of the six New England states. In contrast, the rate in New Hampshire was 116, in Massachusetts it was 103, in Connecticut it was 96, in Maine it was 82, and in Vermont it was 80.

In 2011, the number of registered nurses per 100,000 population in Rhode Island was 1,174, which ranked the state higher than the nation (874 per 100,000 population) and the second highest of the six New England states after Massachusetts (1,321 per 100,000 population), In contrast, the number of registered nurses per 100,000 population in Maine was 1,115, in New Hampshire it was 1,051, in Vermont it was 1,017, and in Connecticut it was 1,014.

In 2007, the number of dentists per 10,000 population in Rhode Island was 5.4, which ranked the state lower than the nation (6.0 per 10,000 population) and the second lowest of the six New England states after Maine (5.0 per 10,000 population). In contrast, the number of dentists per 10,000 population in Massachusetts was 8.2, in Connecticut it was 7.7, in New Hampshire it was 6.3, and in Vermont it was 5.8 //2013//.

E. State Agency Coordination

Section E: State Agency Coordination

Affecting positive change in maternal, child, and family health requires a common vision and collective effort. The DCFHE enjoys strong working relationships with other state departments and community-based agencies and organizations that enhance its efforts to promote and protect the health of MCH populations. /2013/ The DCFHE ensures that resources are coordinated and maximized through a guiding framework anchored in four requirements- integration across programs; equity-based planning, investments, and delivery of programs; application of a life course approach; and, building social and emotional competencies within communities //2013//

State Agency Partnerships

/2013/ The DCFHE's partnerships with other state agencies were described in detail in Section B

(Agency Capacity) of this application.

Legislative Initiatives
/2013/ DCFHE participates on several legislative commissions concerning CYSHCN, including the Joint Commission for the Study of Children with an ASD or other DD in RI and the RI Vision Commission. The DCFHE also participates on the Permanent Legislative Commission of Child Care //2013// ***/2014/ and the Permanent Advisory Commission on Traumatic Brain Injuries //2014//.***

Coordination with Other HEALTH Programs

DCFHE strives to fully integrate Department-wide operations, equity agenda and policy efforts across a number of high priority areas. /2013/ The Maternal and Child Health Block Grant process creates integration and synergy within HEALTH for maternal and child health efforts. The Health Promotion & Wellness Team Initiative for a Healthy Weight works closely with the Perinatal and Early Childhood Health Team to ensure that nutritious foods are served in childcare settings //2013//. The Health Disparities and Access to Care Team collaborates with the Chronic Care and Disease Management Team around training and support to the Community Health Worker Association of Rhode Island (CHWARI), connecting vulnerable populations to the full array of services provided by DCFHE and other state and local agencies. The ***/2014/ Healthy Housing and Lead Poisoning Prevention //2014//*** Program collaborates with the Asthma Control Program assessing the feasibility of training Lead Center staff to incorporate asthma education and other healthy homes initiatives during home visits of children with elevated blood lead levels. The Immunization Program collaborates with the Viral Hepatitis Program ***/2014/ and the Maternal, Infant, and Early Childhood Home Visiting Program //2014//*** to provide necessary vaccinations for at-risk adolescents and adults. /2013/ The Office of Minority Health organizes periodic training for DCFHE staff on Federal Standards for the provision of Culturally and Linguistically Appropriate Services ***/2014/ and has providing training on CLAS standards to maternal and child home visitors //2104//. The Asthma Program, Healthy Homes Team, Health Disparities & Access to Care Team, OSHCN, and Home Visiting Program are all working collaboratively with the Green & Healthy Homes Initiative, Community Health Workers Association of RI, and Health Leads Program to deliver introductory and intermediate healthy housing training for a cross section of external associations and programs that have staff that enter residents' homes. The intent is to cross train all persons that do home visits (e.g. home visitors, community health workers, housing agency staff, homelessness prevention programs, etc.) to understand the elements of healthy housing, assess residences they visit, and make appropriate referrals to help families improve the safety of their housing. /2013/ Last year's Healthy Homes training reached 120 professionals who enter the home of pediatric patients. The May 2012 Introductory training reached an additional 40 professionals. /2014/ The Home Visiting Program works closely with WIC and Title X to outreach to and link pregnant women to services early in pregnancy. The home visiting Program has worked with the Tobacco Program, Healthy homes, and the Asthma Program on the development of screenings that home visitors use with clients.***

The DCFHE has created a model for cross-program integration that includes pooled community investment grants in high need communities called "Health Equity Zones" each with a Center for Health Equity and Wellness. The model includes a statewide Healthy Places Learning Collaborative, with web-based resources, tools, and on-site TA for communities; uniform contract language for all HEALTH contracts to communicate expectations for implementation of health equity work; a collaborative network of state/local stakeholders from multiple coalitions and interest groups doing cross-program state-level strategic thinking; and an on-line relational mapping database of community assets and gaps to ensure that investments and partnerships result in the greatest reach and impact //2014//.

The Healthy Communities Program collaborates with the Initiative for a Healthy Weight to support local partners to conduct a comprehensive community assessment, strategic planning and implementation process in the Olneyville neighborhood of Providence. The project is designed to address social and environmental determinants of health that impact chronic disease with a focus on improving physical activity, nutrition, and chronic disease management as well as lowering rates of tobacco use. Currently the project is implementing the first phase of the Olneyville Community Action Plan.//2013//

The DCFHE participates as a member of the Department's Center for Public Health Communication (CPHC), which sets policy and procedures for strategic and effective communication. /2013/ The DCFHE's Initiative for a Healthy Weight works closely with KIDSNET staff on a childhood BMI electronic data collection project with surveillance and coordination of care applications. The Tobacco Control Program works with the Asthma Control Program and the Healthy Homes and Environment Team to protect residents in multi-unit housing complexes from second-hand tobacco smoke //2013//. ***/2014/ Project Launch, Newborn Screening, Race to the Top, and Home Visiting work with CPHC on the coordinated development and testing of materials //2014//.***

KIDSNET made immunization information available to the Division of Infectious Disease and Epidemiology for disease outbreak investigations. The DCFHE also has ongoing partnerships with HEALTH's Division of Environmental and Health Service Regulation, which provide comprehensive site reviews of licensed health care facilities. The DCFHE works closely with the Office of Vital Records to coordinate data collection at maternity hospitals and to integrate birth certificate data with KIDSNET and newborn screening systems. /2013/ KIDSNET works with the Refugee Health and Lead programs to monitor immunization rates, lead screening and lead safe housing placements for refugee children which are reported on annually. KIDSNET also works with the Adolescent Health and Immunization Programs on access to care and coordination of health services.//2013//. The Asthma Control Program will add an asthma component to KIDSNET to allow providers in the Blackstone Valley Community and St. Joseph Health Centers to refer families to the Breathe Easy at Home Project in the cities of Pawtucket and Providence. ***/2014/ KIDSNET is also working with the Home Visiting Program on the coordination of data collected by Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program //2014//.***

The DCFHE participates on the state's Child Death Review Team, coordinated by HEALTH's Medical Examiner's Office. HEALTH's Division of Laboratories works with the Lead Program to analyze lead screening specimens and collect data. KIDSNET holds quarterly stakeholder meetings to coordinate with all HEALTH programs participating in KIDSNET. DCFHE coordinates with vital records to oversee RI's Newborn Screening Program using vital records for quality assurance and to identify home births which need follow-up to ensure that the infants received appropriate screening.

/2014/ The Family Planning Program collaborates with the Center for Health Data & Analysis through a CDC Births Defects grant to provide a one-year supply of multivitamins to uninsured women who receive a negative pregnancy test result at two Title X sites. The Family Planning Program joined a national partnership with CDC to implement a preconception health social media campaign targeting women 18-44 years. The program worked with the Department's Center for Public Health Communications, the HEALTH Promotion and Wellness Team, and the Center for Data & Analysis, to include integrated messaging through the Department's social media channels.

The Immunization Program coordinates vaccine clinics with CEPR, collaborates with OSHCN's Adolescent Transition Program and collects and shares lead screening data from childcare settings //2014//.

Collaboration with Private Organizations & Associations

/2013/ The Division's partnerships with private, community-based organizations and associations are extensive. Community development is a DCFHE priority. There are no local health departments in Rhode Island. Community driven efforts are necessary to build and sustain local public health infrastructure //2013//.

Private Provider Community: The Medical Director is active in professional provider organizations. DCFHE staff has worked closely with the RI Chapter of the American Academy of Pediatrics (AAP), the RI Chapter of Family Practitioners, and the RI Chapter of the American Academy of Obstetricians and Gynecologists on a number of DCFHE initiatives, including ***/2014/ the development and implementation of the Preconception Health Statewide strategic Plan //2014//***, KIDSNET, RI LAUNCH, Watch Me Grow, and Adolescent Medical Home. DCFHE works closely with the Physicians' Committee for Breastfeeding in RI. All primary care providers use KIDSNET. DCFHE staff members provide technical assistance to Rhode Island CATCH projects funded by the AAP including an adolescent medical home project in Woonsocket and Pawtucket, and an effort to increase prenatal care in the first trimester in Washington County. RI maintains a universal vaccine policy and provides vaccines to all providers at no cost. DCFHE coordinates the Primary Care Physician Advisory Committee (PCPAC) which advises HEALTH on programmatic and policy issues impacting primary care in Rhode Island. ***/2014/ Recent advisory topics include primary care quality improvement measures, roles of OB/GYN in primary care, and financing a primary care model. Several private urologists in the community partner with the DCFHE to provide no cost vasectomies to uninsured and under-insured men over the age of 21 //2014. The AAP is working in conjunction with the Immunization Program on a provider site-based CQI initiative //2014//.***

DCFHE's programs actively collaborate with the Community Health Worker Association (CHWA) of RI on organization development issues like strategic planning, CHW training opportunities like healthy housing and health reform, and on the development of a statewide core training curriculum for CHWs. ***/2014/ Core competency curriculum for CHWs were developed, piloted, and implemented in late 2012//2014//.***

A significant proportion of DCFHE investments support activities in Community Health Centers including, WIC, Family Planning, PPEP Parent Consultants, WHSRP, Tobacco Cessation, chronic disease management, Watch Me Grow, and three school based health centers. The DCFHE works directly with individual Community Health Centers and the RI Health Center Association on larger policy issues impacting community health services delivery, such as the RI Chronic Care Collaborative and the transition toward Patient Centered Medical Home (PCMH). The DCFHE, Chronic Care and Disease Management Teams continue to contract with 18 RICCC health centers to improve care among chronic disease patients using the Care Model and Model of Improvement. This includes 10 sites that serve pediatric asthma patients.

The DCFHE has strong partnerships with several hospitals in RI. DCFHE provides funding to the Children's Neurodevelopment Center (CNDC) at Hasbro Children's Hospital. The Newborn Screening Program works closely with Women & Infants' Hospital and other birthing hospitals in RI around training and quality assurance. The Newborn Screening Program also works closely with ***/2014/ health plans, //2014//*** metabolic, cystic fibrosis, ***/2014/ endocrine, immunology //2014//***, and hemoglobinopathy clinics at Rhode Island Hospital for diagnosis, treatment, and follow-up. ***/2014/ Women & Infants Hospital, Kent County Hospital, Newport Hospital are piloting pulse oximetry screening to assess the feasibility of screening all Rhode Island newborns for Critical Congenital Heart Disease prior to hospital discharge. The goal is to expand screenings to all of the Rhode Island birthing hospitals. Results of newborn CCHD screening will be available soon to primary care providers through KIDSNET. The Newborn Screening Program is also working with the birth Defects Program and Cardiologists to report cases of Critical Congenital Heart Disease to the Birth Defects Programs //2014//.*** Newport Hospital is collaborating with the DCFHE and other partners on the Newport County Healthy Communities initiative. The DCFHE supports lead and immunization clinics for uninsured

children at St. Joseph Hospital. The Birth Defects Program has been working closely with Women & Infants', Kent County, and Hasbro Children's Hospital to improve case ascertainment. Representatives from these hospitals provide information, consultation, and guidance; several are members of the Birth Defects Advisory Council. The Immunization Program provides all birthing hospitals in the state with a supply of Hepatitis B vaccine so that newborns receive the birth dose prior to discharge and the vaccination is reported to KIDSNET. PPEP Parent Consultants are placed at Hasbro Children's Hospital, Butler Hospital, Memorial Hospital, St. Joseph's Hospital Asthma Program and Women & Infants' Hospital. The DCFHE works with Bradley Hospital (the state's psychiatric hospital for children and adolescents) on a mental health resource guide and on developing mid-level mental health services for children graduating from intensive programs.

DCFHE, with the largest Medicaid insurer in the state, evaluated the PPEP Parent Consultant Program. The utilization analysis demonstrated that CSHCN who received PPEP services had lower health care costs as they had higher utilization of community based services, and lower institutional level of care services. The DCFHE continues to work with the two Managed Care Medicaid organizations in RI to share data and increase support for public health efforts for the vulnerable Medicaid population.

The DCFHE has strong partnerships with several child serving agencies through First Connections. Home visitors provide home assessments, connection to community services, and help with child development and parenting for almost 25% of all families with newborns each year. First Connections collects housing related information during the initial home visit and the DCFHE will use this data to promote access and availability to healthy housing. /2013/ The DCFHE has developed partnerships with social service agencies in the community to provide evidence-based home visiting to children in 6 communities at risk of poor outcomes. These evidence-based models are Healthy Families America, Nurse Family Partnership, and Parents as Teachers //2013//.

The Child Care Support Network (CCSN) works closely with the child care provider community and families. CCSN is made up of a team of professionals who work with licensed center-based and home-based child care providers to improve the quality of care for all children in the following areas: health and safety, nutrition, physical activity curriculum development, early literacy, CSHCN, child development, family involvement, and mental/behavioral health.

Healthy Mothers/Healthy Babies Coalition, a partnership of individuals, professionals, and government organizations devoted to improving birth outcomes. DCFHE participates on it. ***/2014/ The Rhode Island Task Force on Premature Births, a group of community stakeholders led by HEALTH, March of Dimes, and women & Infants Hospital, works to reduce the rate of premature births in Rhode Island //2014//.*** Rhode Island Kids Count is a children's policy organization that provides information on child wellbeing and stimulates state dialogue on children's issues. Each year, the agency publishes a fact book, which provides detailed community-by-community visuals of the condition of children in RI. The DCFHE provides a significant proportion of data utilized in the fact book. The DCFHE works closely with Covering Kids on community systems development initiatives to increase children's access to Medicaid. Childhood Lead Action Project is the only advocacy agency in RI dedicated to addressing the problem of childhood lead poisoning and is a member of the Healthy Housing Collaborative.

/2014/ DCFHE staff members provide technical assistance to community partners to develop and implement a comprehensive community assessment and strategic planning process designed to address social and environmental determinants of health that impact chronic disease //2014//. /2013/ The DCFHE's State Office of Rural Health supports systems building efforts in non-metro regions of the state. Current projects focus on improving children's mental health, increasing use of preventive care by teens and young women, and expanding care coordination efforts //2013//.

Rhode Island Public Health Association (RIPHA) is the state affiliate of the American Public

Health Association; DCFHE staff members participate on the board and other efforts. Rhode Island Public Health Institute (RIPHI) was formed to organize and activate private sector professionals interested in the advancement of public health in RI. DCFHE personnel participates on the board and collaborates on community assessments and workforce development efforts and other public health initiatives. ***/2014/ The RI Healthy Schools Coalition and guides communities and their schools to improve the nutritional and physical well-being of children. The Coalition supports School District Health and Wellness Subcommittees' healthy eating and active living efforts //2014//.*** DCFHE staff members participate on the steering committee and related workgroups.

The Rhode Island Alliance is a statewide organization dedicated to reducing teen pregnancy and empowering pregnant and parenting teens. The Alliance works in collaboration with individuals and agencies throughout Rhode Island to provide resources and advocacy for youth and young families. DCFHE's teen pregnancy prevention efforts are aligned with the Alliance's statewide plan. Rhode Island Breastfeeding Coalition (RIBC) includes community organizations and groups dedicated to supporting and promoting breastfeeding in RI. Members include lactation consultants from local birthing hospitals, physicians, and other health care professionals. Rhode Island Food Dealers Association acts as the liaison between the WIC Program and 25 WIC vendors throughout the state. Childhood Immunization Action Coalition consists of DCFHE staff, community-based agencies, civic organizations, medical care providers, schools, Head Starts, childcare center-based nurse consultants, hospitals, and health insurance plans. The purpose of the Coalition is to share strategies and develop plans for improving utilization rates. Rhode Island Certified School Nurse Teachers' Association works closely with DCFHE on implementing health service requirements in schools and provides input and feedback for the school nurse teachers' conference.

The DCFHE actively collaborates with a number of family leadership and parent support agencies and programs. The DCFHE works closely with leadership from the RI Family Voices and participates in the Family Voices Leadership team. The DCFHE also contracts with the RI Parent Information Network (RIPIN) to provide training and technical assistance to the Parent Consultant Program and the Parent Support Network.

HEALTH and the DCFHE have active relationships with many of the state's colleges and universities. HEALTH has formal agreements with area institutions of higher education to facilitate staff training and collaborative research and grant writing. In partnership with three Rhode Island Colleges, the Lead Program offers training to nursing students about environmental threats in the home. The DCFHE is also working with the RI Area Health Education Center (housed at Brown University) to develop and offer multidisciplinary training on early childhood mental health. Through the Joint Legislative Commission on the Educating Children with Autism Spectrum Disorders, the DCFHE is designing a teacher competency certification in ASD and incorporating these competencies into undergraduate special education curriculum. The DCFHE partners with Brown University faculty on a variety of special needs, especially Autism and other developmental disabilities.

Ocean State Adult Immunization Coalition has a formal contract with HEALTH to provide education and outreach to improve adult immunization. ***/2014/ The Immunization Program has developed and implemented a web-based reporting system to monitor school immunization coverage. All schools with grades kindergarten and 7th grades are required to report to the Department annually the number of children who are not fully immunized as well as those who have exemptions //2014//.***

The Rhode Island Association of School Principals is collaborating with HEALTH on a toolkit supporting mental health promotion among school age children. /2013/ DCFHE is on the founding board of the RI Full Service Community School Alliance including the COZ and full service community school efforts in the state. The alliance seeks to build on local efforts and support other communities in the development of full service community schools //2013//. ***/2014/RI***

Asthma Control Coalition works closely with the RI Asthma Control Program to reduce asthma hospitalization and ED visit rates. The Asthma in Schools Committee targets youth by addressing the environmental health of schools, communication with school nurse teachers, and improvement in asthma care among primary care providers //2014//.

RI Asthma Emergency Department (ED) Diversion Pilot Project Advisory Committee was convened by the RI Asthma Control Program and the Office of CYSHCN to provide guidance on the development, implementation, and evaluation of the pilot project in partnership with Hasbro Children's Hospital, St. Joseph Health Center, and RI Parent Information Network to reduce asthma ED visits by providing home visits to children who enter the ED or are admitted to Hasbro due to asthma. ***/2014/ The Home Asthma Response Program, formerly called the RI Asthma ED Diversion Pilot Project, reached 53 patients in Phase II. Preliminary results of Phase I show a significant reduction in asthma ED visits among the 29 participating patients //2014//.***

The Diabetes Prevention and Control Program funds a follow-up demonstration pilot project to ensure that women who have been diagnosed with gestational diabetes receive oral glucose testing and referrals to appropriate services for diabetes or pre-diabetes care. Women with gestational diabetes who go on to be diagnosed with pre-diabetes will be referred to an evidence-based program provided by the YMCA. ***/2014/ The Gestational Diabetes Project, funded by Title V and the Diabetes Prevention and Control Program at HEALTH ended on July 30, 2012. Project data demonstrated that intensive intervention consisting of arranging testing appointments, tracking test completion, and providing reminders for attendance and rescheduling missed appointments led to improved post partum glucose tolerance testing rates from 43.1% to 59.4%. 100% of the women diagnosed with pre-diabetes, or at risk for diabetes, were refereed to the YMCA's Diabetes Prevention Program //2014//.***

Coordination with Other Federal Grant Programs

DCFHE programs receive funding from several federal grant programs. These programs include: Minority Health (Office of the Secretary DHHS), Family Planning (Title X), WIC (USDA), Newborn Hearing Screening (CDC), RI LAUNCH (SAMSHA), /2013/ Maternal, Infant, and Early Childhood home Visiting (HRSA) //2013//, PRAMS (CDC), Immunization (CDC), ABLES (CDC) //2013//, ***/2014/ Building Resilience Against Climate effects (CDC) /2014//, Tobacco Control Program (CDC), Initiative for Healthy Weight (CDC), SafeRI, Violence and Injury Prevention Program (CDC and SAMHSA), /2014/ Oral Health Program (CDC and HRSA), Integrated Diabetes, Heart Disease, and Obesity (CDC) //2014//*** and Teen Pregnancy Prevention and Child Care Support Network (ACF). /2013/ DCFHE programming is also supported through several HRSA grants including: Universal Newborn Hearing Screening, President's New Freedom Initiative Integrated Community Systems for CSHCN, State Early Childhood Comprehensive Systems, State Implementation Grant for ASD and other Developmental Disabilities, Healthy Tomorrows Partnership for Children, Primary Care Services, and the Rural Health Program and Healthy Tomorrows Partnership for Children. The DCFHE also receives federal funding from EPA for the environmental lead, radon, and asbestos programs //2013//.

Advisory Committees

The DCFHE has established advisory committees and workgroups for many of its programs that include professional and consumer representation. Current DCFHE advisory and workgroups include the Childhood Immunization Action Coalition, Vaccine Advisory Committee, Influenza Task Force, School Immunization Improvement Advisory Committee, Successful Start Steering Committee and a newly formed adolescent transition team, WIC Vendor Advisory Council, Oral Health Professional Advisory Council, Healthy Housing Collaborative, and newborn screening advisory committees, Adolescent Health Advisory Committee, Primary Care Physicians' Advisory Committee, Women's Health Advisory Committee and the Refugee Health Advisory Committee. Other committees supported by DCFHE include: Rhode Island Prematurity Task Force, Healthy

Homes Collaborative, Autism Spectrum Disorder Advisory Board, Injury Community Planning Group, Sexual Violence Prevention Planning Committee, the Tobacco Control Coalition, ***/2014/ and the Home Visiting Leadership Council //2014//.*** /2013/ The DCFHE's Initiative for a Healthy Weight works closely with KIDSNET staff on a childhood BMI electronic data collection project with surveillance and coordination of care applications. The Tobacco Control Program works with the Asthma Control Program and the Healthy Homes and Environment Team to protect residents in multi-unit housing complexes from second hand-tobacco smoke //2013//.

F. Health Systems Capacity Indicators

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	49.2	57.2	46.9	28.9	30.1
Numerator	300	344	282	166	173
Denominator	60934	60139	60139	57448	57448
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012
Provisional data reflects a slight increase in the rate of children hospitalized for asthma less than five years of age.

Denominator for 2011 and 2012 is from the 2010 US Census.

Notes - 2011
The rate of asthma hospitalization decreased by 40% for children under age five between 2010 and 2011.
The reason for the one-and two-thirds decrease in rates of asthma hospitalization for children less than five years of age, between 2010 and 2011 is not clear at this time. However, changes in the health care laws, high immunization rates, insurance policies, asthma education and interventions and state population demographic changes may have impact on the rate changes.

Notes - 2010
2010: Based on the pediatric asthma hospitalization rates of Rhode Island children aged 0-4, the 2010 rate has decreased compared to the 2009 rate.

Data for 2010 are provisional and the denominator is from the US Census Estimates.

Narrative:
/2014/ Asthma may be used to measure the extent to which children are receiving quality disease preventive care and health promotion education. Access to and utilization of appropriate medical care can often prevent severe episodes of asthma. Increased asthma hospitalization rates may be a consequence of inadequate outpatient management and diminished access to medical home. The goal is to reduce asthma hospitalizations for

children less than five years old. The related Healthy People 2020 target is to reduce hospitalizations to 18.1 hospitalizations per 10,000 population.

In Rhode Island, the rate of asthma hospitalizations was 46.9 in 2010 and 28.9 in 2011 (a 40% decrease). In 2012, the rate was 30.1 (provisional data). In 2011, more than half (58%) of the children who were hospitalized for asthma lived in the state's culturally diverse, older, urban, communities. The reason for the decrease in rates of hospitalization between 2010 and 2011 is not clear. Changes in the health care laws, insurance policies, increased asthma education and interventions, and state population demographics may have had an impact on the rate changes. However, the number of children hospitalized with asthma in Rhode Island remains small (173 children in 2012 and 166 in 2011) //2014//.

Nine health centers continue their commitment to improving the quality of pediatric asthma care through the RI Chronic Care Collaborative. Phase 1 of the Home Asthma response Program included 29 participants. ***/2014/ An additional 70 participants completed the program in Phase 2 through September 2012 //2014//.*** /2012/ The first referrals for the Breathe Easy at Home Project took place in April 2012 //2013//.

First Connections and MIECHV Program home/environmental assessments were modified to be more comprehensive, encompassing healthy homes, asthma, and lead. The DCFHE is also collecting 'Healthy Housing Checklist' data submitted by certified lead centers, environmental lead inspectors and other home visitors. /2013/ First Connections/MIECHV integrates information about reducing asthma and promoting healthy housing in all home visits.

The Asthma Control Program partnered with Special Health Care Needs, the Newborn and Early Childhood Screening & Follow Up Programs, the Healthy Homes Program and the US EPA to offer the National Center of Healthy Housing's Healthy Housing Training in May 2012. Over 40 professionals and community health workers who provide a variety of services in the homes of pediatric patients participated in the training //2013//.

The Tobacco Control Program has funded efforts for the Providence Housing Authority to begin the implementation of smoke-free policy in the housing units in five high-rise buildings. All of the Providence Housing Authority housing complexes were smoke-free by 2012.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 02 - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	88.9	90.1	91.5	87.5	91.0
Numerator	11674	11900	11588	10217	11780
Denominator	13135	13204	12658	11677	12945
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012

Data are provided by RI Department of Human Services the Center for Child and Family Health. Data for 2012 shows a slight increase compared to 2011.

Notes - 2011
Data are provided by RI Department of Human Services the Center for Child and Family Health. Data for 2011 shows a decline compared to 2010.

Notes - 2010
Data are provided by RI Department of Human Services the Center for Child and Family Health. Data for 2010 shows a slight increase compared to 2009.

Narrative:
/2014/ The goal is to increase the adequacy of primary care for Medicaid enrollees. The related Healthy People 2012 target is to increase the proportion of persons who receive appropriate evidence-based clinical preventive services. In Rhode Island, the percentage of Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen has been about the same over the past several years, ranging from 88.9% in 2008 to 91.0% in 2012 (provisional data) //2014//.

Medicaid-eligible infants in Rhode Island are enrolled in one of two Medicaid managed care health plans. ***/2014/ The RI Office of Health & Human Services (OHHS) monitors health plan performance on EPSDT and has developed mechanisms to reward the plans based on performance //2014//.***

HEALTH has various mechanisms to follow-up on children with missed screening opportunities, including home visiting, KIDSNET data tracking and screening support systems. KIDSNET collects data on newborn developmental, bloodspot, and hearing screening. /2013/ A new report for primary care providers is in development, which will provide primary care providers with a list of their patients needing follow-up from newborn hearing screening.

KIDSNET partners with the RIte care health plans to provide immunization data so that the plans can focus outreach efforts on children and practices on under immunized children. KIDSNET is working with Successful Start to develop collection and appropriate sharing of developmental screening data. A pilot project for conducting and recording developmental screening in KIDSNET has begun at 4 primary care and 2 child care sites //2013//. KIDSNET is working with Medicaid on implementing a data-sharing plan. /2013/ KIDSNET is working the RIte Care health plans to establish a regular update of insurance information in KIDSNET. This will allow more accurate and current evaluations of preventive health care recorded in KIDSNET by insurance status //2013//.

/2014/ Special Health Care Needs partnered with the state's Medicaid program throughout 2012 to implement the Health Homes Initiative for CYSHCN through the CEDARR program. CYSHCN in the CEDARR program receive annual BMI, developmental screening, and mental health screening.

First Connections and MIECHV programs utilize KIDSNET to determine if infants and children are behind on the EPSDT schedule of screening. If they are determined to be behind, First Connections and MIECHV home visitors work with the family and the child's pediatrician to get the child caught up. KIDSNET staff train home visitors on how to utilize KIDSNET data appropriately//2014//.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 03 - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	1	1	1	1	1
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2012
In Rhode Island, children in SCHIP are aged 8-18. Infants and children less then 8 years old are enrolled in our Medicaid Managed Program [RiteCare]. This Health Systems Capacity Indicator does not apply to Rhode Island.

Notes - 2011
In Rhode Island, children in SCHIP are aged 8-18. Infants and children less then 8 years old are enrolled in our Medicaid Managed Program [RiteCare]. This Health Systems Capacity Indicator does not apply to Rhode Island.

Notes - 2010
In Rhode Island, children in SCHIP are aged 8-18. Infants and children less then 8 years old are enrolled in our Medicaid Managed Program [RiteCare]. This Health Systems Capacity Indicator does not apply to Rhode Island.

Narrative:
/2014/ Rhode Island SCHIP only serves children aged 8-18 years, children less than 1 year old are covered by Rite Care. Ninety-two percent (92%) of children aged less than 1 year old and covered by Rite Care received at least one periodic screen. This health systems capacity indicator does not apply to Rhode Island //2014//.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 04 - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	77.8	77.2	83.6	84.1	88.6
Numerator	8789	8342	8873	8579	7948
Denominator	11295	10800	10616	10207	8966
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2012
2012: Data for 2012 are provisional, however, there is an increase from previous years from around 84% to 88.6%.

Notes - 2011
2011: Percent of women receiving adequate or adequate plus prenatal visits remained about the same for both 2010 and 2011.

Notes - 2010
2010: Data increased from previous years from around 77% to 83.6% for 2010.

Narrative:
/2014/ Adequate prenatal care is an effective intervention that improves pregnancy outcomes, including reducing infant mortality. The two-part Kotelchuck Adequacy of Prenatal Care Utilization Index combines independent assessments of the timing of prenatal care initiation and the frequency of visits after initiation. The goal is to increase the adequacy of prenatal care utilization. The related Healthy People 20120 target is to increase the proportion of pregnant women who receive early and adequate prenatal care to 77.6%. /2014/ In Rhode Island, the percentage of women giving birth who had observed expected prenatal visits greater than or equal to 80% on the Kotelchuck Index has steadily increased from 77.8% in 2008, 77.2% in 2009, 83.6% in 2010, 84.1% in 2011 (provisional data), and 88.6% in 2012 (provisional data) //2014//.

/2013/ In Rhode Island, pregnant women with incomes up to 250% of the Federal Poverty Level are eligible for RIte Care, which provides a comprehensive pregnancy benefit package. The DCFHE works to increase access to prenatal care through the Title X Family Planning Program and the First Connections /2013/ and MIECHV Home Visiting Programs //2013//. ***/2014/ All women enrolled in prenatal home visiting programs are encouraged and supported to access prenatal care //2014//.*** Women receiving pregnancy tests at Title X Family Planning agencies receive counseling and education and referral to appropriate medical services. Agencies help connect women to the services they need early in pregnancy, or before a pregnancy, to improve the health of the mother and her baby.

/2014/ The DCFHE, in partnership with Women & Infants Hospital, is currently working with the RI Task Force on Premature Births to develop and implement preconception risk assessment and screening templates by identifying priority areas based on state data to better address the needs of women before and between pregnancies //2014//. /2013/ The DCFHE is also working with community partners to identify resources and services in order to develop a referral resource for providers to support the reproductive needs of their patients, including home visiting //2013//.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 07A - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	82.4	83.2	82.5	83.2	94.7
Numerator	84717	89746	92701	89746	95248
Denominator	102774	107887	112376	107887	100630
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2012
Data are estimated and reflect children under the age of 19.
Source: The 2013 Rhode Island Kids Count Factbook.

The percent of medicaid eligible children who received a service paid by Medicaid increase to 94.7% compared to previous years where the pecent remained around 83%.

Notes - 2011
Data are estimated and reflect children under the age of 19.
Source: The 2014 Rhode Island Kids Count Factbook.

Percent of potentially Medicaid eligible children who received a service paid by Medicaid remains about the same for 2008 - 2011.

Notes - 2010
Data are estimated and reflect children under the age of 19.
Source: The 2011 Rhode Island Kids Count Factbook.

Narrative:
/2014/ Financial access to health care does not guarantee that all children will enroll and access health care, but insured children are more likely to get care. The goal is to enroll all Medicaid eligible children in Medicaid ensuring better access to health care services. The related Healthy People 2020 target is to increase the proportion of persons with health insurance to 100%. In 2010, 82.5% of potentially eligible Medicaid children in Rhode Island received a service paid for by the Medicaid Program. In 2011, this percentage was 83.2%, and in 2012, it was 94.7% //2014//.

The DCFHE manages several programs designed to facilitate access to RIte Care by eligible children and families including WIC, Childcare Support Network, ***/2014/ First Connections, MIECHV Programs, and PPEP //2014//*** by referring families who are uninsured or underinsured directly to Medicaid. ***/2014/ MIECHV programs also ensure that those families who are referred and enrolled continue to maintain health care coverage //2014//***. KIDSNET partners with managed care health plans to exchange lead screening and immunization data to enhance their capacity to provide targeted outreach to members needing those services. /2013/ KIDSNET and WIC developed and implemented an interface that will improve the capacity to monitor lead screening and immunization of WIC clients. The health plan that provides Medicaid managed care (RIte Care) coverage agreed to provide enrollment data to KIDSNET on a regular basis. Technical procedures for the data transfer are being developed //2013//.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 07B - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012

Annual Indicator	70.5	70.4	67.9	71.6	70.5
Numerator	14976	12857	11186	12364	14107
Denominator	21250	18254	16464	17265	20007
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2012
Data are provided by RI Department of Human Services the Center for Child and Family Health. Except for the decline in 2010, data reflects that about 70% of EPSDT eligible children received some Medicaid dental service during the year.

Notes - 2011
Data are provided by RI Department of Human Services the Center for Child and Family Health.

Notes - 2010
Data are provided by RI Department of Human Services the Center for Child and Family Health. Revised data reflects a decrease from 70.4% in 2009 to 67.9% in 2010.

Narrative:
/2014/ About 88% of Rhode Island's population on public water systems receives fluoridated water. Children in Rhode Island who are eligible for Medical Assistance (MA) receive dental care through either RIte Smiles or MA. Which program they are eligible for depends on the age of the child. RIte Smiles is a managed care dental plan for children who are eligible for RI MA. Children are eligible for RI Smiles if they are born after May 1, 2000.

Data for this health capacity indicator from 2008 through 2012 has remained about the same, ranging from 70.5% in 2008 to 70.5% in 2012 (provisional data). In 2011, it was 71.6% (provisional data) //2014//. As the state continues to work to improve the existing state infrastructure for providing dental services for Medicaid-eligible children through RIte Smiles, this percentage may increase over time. /2013/ Two major goals of RIte Smiles are to increase the percentage of children on Medicaid who receive dental services, and to shift, over time, the types of dental services these children receive to more preventive care.

/2014/ Information about RIte Smiles and MA, community health centers with dental clinics, school-based dental programs, and other oral health programs in Rhode Island are posted on the HEALTH and DHS websites. In addition to covering dental visits for children before the age of one, Rhode Island is one of 40 state Medicaid programs that reimburse primary care providers for preventive oral health services for very young children, including risk assessment, caregiver education, and fluoride varnish application //2014//.

First Connections, MIECHV, and WIC programs provide culturally appropriate information about early childhood caries/prevention. The Child Care Support Network, Child Care Health Consultants offers health consultation to child care centers conducting child health record reviews, providing staff training and technical assistance, distributing educational materials, and working directly with families to provide referrals to community services and resources.

School-based dental/sealant programs are located in many Rhode Island communities. The Association of State and Territorial Dental Directors recommends that schools with 50% or more students eligible for free or reduced school meals programs are targeted for school-based

services. During the 2011-2012 school year, 65 RI elementary schools meet eligibility criteria, and of these, 60 schools (93%) were associated with a school-based/linked dental sealant program 2013. ***/2014/ However, it is anticipated that during the 2013-14 school year, the percent of schools meeting eligibility criteria that are linked with school-based dental services will decrease to 33% due to the discontinuation of services provide by the largest school-based dental program. The agency that used to provide sealants in Providence and Pawtucket dropped out of the program due to inadequate funding. HEALTH is exploring ways to resolve this barrier //2014//.***

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 08 - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	1	1	1	1	1
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2012
Please note that this health system capacity indicator does not apply to Rhode Island.

The Rhode Island Department of Health has not in the past year paid for any rehabilitation services through the CSHCN Program for three primary reasons. (1) The Early Intervention Program [EI] transferred to the Department of Human Services and a private insurance mandate passed in 2005. (2) The State in late 2005, eliminated carve-out funding of services for children and youth with complex special needs, and requested insurers to reimburse for these services. (3) SSI recipients are enrolled in Medicaid which funds rehabilitation services

Notes - 2011
Please note that this health system capacity indicator does not apply to Rhode Island.

See extended note in 2010.

Notes - 2010
Please note that this health system capacity indicator does not apply to Rhode Island.

The Rhode Island Department of Health has not in the past year paid for any rehabilitation services through the CSHCN Program for three primary reasons. (1) The Early Intervention Program [EI] transferred to the Department of Human Services and a private insurance mandate passed in 2005. (2) The State in late 2005, eliminated carve-out funding of services for children and youth with complex special needs, and requested insurers to reimburse for these services. (3) SSI recipients are enrolled in Medicaid which funds rehabilitation services

Narrative:

Rhode Island is a 1914A state and all children on SSI are enrolled in Medicaid. Medicaid benefits are extensive and include rehabilitative services. The CSHCN Program does not provide direct services. It is the goal of CSHCN Program to build resources in the community and sustain the provision of services for children with complex medical needs to other systems of care. ***/2014/ As of December 2012, 4,085 children under age 16 years were receiving federally administered SSI payments//2014//.*** This health systems capacity indicator does not apply to Rhode Island.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2011	payment source from birth certificate	8.4	6.3	7.5

Narrative:
/2014/ Using birth certificate data, the percent of low birth weight infants (<2500 grams) for Medicaid, non-Medicaid, and all MCH populations in the state in 2011 was higher for the Medicaid population (8.4%) than it was for the non-Medicaid population (6.3%). Disparities remain between recipients of Medicaid and those insured by other means. The overall percentage for all MCH populations statewide was 7.5% //2014//.

Title X Family Planning agencies provide pregnancy testing services for at-risk populations. Women who receive positive pregnancy tests through the agencies are referred to appropriate medical and community services. Women who receive negative pregnancy tests are provided preconception counseling and also referred to services, as needed. The WIC Program provides nutrition assessments, coordination of care, education, and nutritious foods to low-income pregnant women (the majority of whom are enrolled in RIte Care) to promote healthy pregnancies and healthy births. Finally, the DCFHE, in partnership with Woman and Infants Hospital of Rhode Island, supports the RI Task Force on Premature Births and recommends policies, and programs to reduce low birth weight. The Tobacco Control Program provides funds to train providers to refer pregnant women to cessation services.

/2013/ Rhode Island supports a continuum of home visiting initiatives, including First Connections and three evidence-based MIECHV models: Nurse Family Partnership, Healthy Families America, and Parents as Teachers //2013//.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**

State					
Infant deaths per 1,000 live births	2011	payment source from birth certificate	7.9	4.7	6.4

Notes - 2014
There were 70 resident infant deaths for 2011. Insurance type at birth for four of the infant deaths were unknown. The 'ALL' population includes those with unknown insurance.

Narrative:
/2014/ Data for 2011 indicate that the perinatal mortality rate varies based on health insurance status. In 2011, it was higher for the Medicaid population (7.7) than it was for the Non-Medicaid population (4.1). The overall rate statewide in Rhode Island in 2011 was 6.0 per 1,000 population. //2014//. /2013/ Please note that in Form 18, the 'all" category includes those with and 'unknown" or 'unreported" health insurance status.

/2013/ The Pregnancy Risk Assessment Monitoring System (PRAMS) collects information to improve the health of mothers and infants by reducing poor pregnancy outcomes such as low birth weight, infant mortality and morbidity, and maternal morbidity. PRAMS is an ongoing survey of recent mothers to learn about their behaviors and experiences before, during and after pregnancy //2013//.

/2014/ The Title X Family Planning Program has partnered with the Center for Health Data & Analysis to provide multivitamins with folic acid to uninsured women who receive a pregnancy test at two Title X agencies. Folic acid supplementation reduces the likelihood of neural tube birth defects.

The DCFHE has partnered with the March of Dimes Rhode Island Chapter of the Association of State and Territorial Health Officials presidential challenge to reduce the rate of preterm birth by 8% by 2015. Through this partnership, the Family Planning Program and the Home Visiting Program along with the March of Dimes have focused on policy efforts to eliminate non-medically necessary elective inductions and deliveries prior to 39 weeks, as well as to support Centering Pregnancy Initiatives in the state.

The DCFHE was selected to take part in the Association of Maternal & Child Health Program Action Learning Collaborative to improve birth outcomes through health care reform. Through a team effort of internal and external partners, the project will enhance the capacity of the state's MCH programs and community partners maximizing the current environment of opportunity and coordinating multiple efforts to improve birth outcomes //2014//.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in	2011	payment source from birth certificate	83.2	93	87.9

the first trimester					

Notes - 2014
Records with unknown month of prental care are excluded.

Narrative:
2014/ Using birth certificate data, the percent of infants born to pregnant women receiving care in the first trimester in 2011 was lower for Medicaid populations (83.2%) as compared to non-Medicaid populations (93.0%) with a total of 87.9% across all MCH populations ***//2014//. Please note that in Form 18, the "all" category includes those with an "unknown" or "unreported" health insurance status.***

/2013/ The DCFHE supports numerous activities targeted to ensuring women access to prenatal care early in their pregnancy, including WIC, family planning and home visiting. The WIC Program provides nutrition assessments, coordination of care, education, and nutritious foods to low-income pregnant women to promote healthy pregnancies and healthy births. The Title X Family Planning agencies provide pregnancy testing services to at-risk populations. Women who receive positive pregnancy tests through the agencies are referred to appropriate medical and community services. Women who receive negative pregnancy tests are provided preconception counseling and also referred to services, as needed //2013//.

/2014/ The DCFHE, in partnership with the RI Task Force on Premature Births, worked to develop and implement preconception risk assessment and screening templates by identifying priority areas based on state data to betters address the needs of women //2014//. /2013/ The DCFHE is also working with community partners to identify resources and services in order to develop a referral resource for providers to support the reproductive needs of their patients, including home visiting //2013//.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2011	payment source from birth certificate	79.1	89.3	84.1

Narrative:
/2014/ Using birth certificate data, the percent of infants born to pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% of the Kotelchuck Index), in 2011 was lower for Medicaid populations (79.1%) compared to non-Medicaid populations (89.3%). This indicator is 84.1% for all MCH populations statewide //2014//. Please note that in form 18, the 'all" category includes those

with an "unknown" or "unreported" health insurance status.

/2013/ The DCFHE supports numerous activities targeted to ensuring women access to prenatal care early in their pregnancy, including WIC, family planning, and home visiting. The WIC Program provides nutrition assessments, coordination of care, education, and nutritious foods to low-income pregnant women. The Title X Family Planning agencies provide pregnancy testing services to at-risk populations. Women who receive positive pregnancy tests through the agencies are referred to appropriate medical and community services. Women who receive negative pregnancy tests are provided preconception counseling and also referred to services, as needed //2013//.

/2014/ The DCFHE, in partnership with the RI Task Force on Premature Births, worked to develop and implement risk assessment and screening templates by identifying priority areas based on state data to better address the needs of women //2014//. /2013/ The DCFHE is also working with community partners to identify resources and services in order to develop a referral resource for providers to support the reproductive needs of their patients, including home visiting. //2013//.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2012	250
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2012	

Notes - 2014
Infants qualify for Medicaid if <250% of poverty level.

Notes - 2014
Infants are not covered under CHIP. Rhode Island infants are covered under Medicaid.

Narrative:
Infants (0-1) qualify for Medicaid if <250% of the federal poverty level (FPL). SCHIP does not include infants.

Eligibility for Medicaid and SCHIP has not changed. Rhode Island continues to enjoy one of the lowest rates of uninsured among children in the country. The DCFHE supports access to Medicaid through WIC, Childcare Support Network, the First Connections /2103/ and MIECHV programs //2013//, and the adolescent health program by referring families who are uninsured or underinsured directly to Medicaid. All WIC applicants are screened for health insurance, and referred as needed to Medicaid.

/2013/ The Title X Family Planning agencies provide services to at-risk populations. The program identifies health risks among women and connects women to medical and community services, including RIte Care //2013//.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2012	250
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 8 to 18) (Age range to) (Age range to)	2012	250

Notes - 2014
Children aged 1 - 18 qualify if <100% of Povery Level.

Notes - 2014
Children aged 8 - 18, qualify if 100% - 250% of poverty level

Narrative:
Children (1-18) qualify for Medicaid if <250% of the FPL. Children (8-18) qualify for SCHIP if <250% of the FPL.

Eligibility for Medicaid and SCHIP has not changed. Rhode Island continues to enjoy one of the lowest rates of uninsured among children in the country.

The DCFHE supports access to Medicaid through WIC, Childcare Support Network, ***/2014/ First Connections, MIECHV Program, PPEP, //2014//*** and adolescent health program to refer families who are uninsured or underinsured directly to Medicaid. All WIC applicants are screened for health insurance, and referred as needed to Medicaid.

/2013/ The Title X Family Planning agencies provide services to at-risk populations. The program identifies health risks among women and connects women to medical and community services, including RIte Care //2013//.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2012	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP**	**YEAR**	**PERCENT OF POVERTY LEVEL**

programs for infants (0 to 1), children, Medicaid and pregnant women.		SCHIP
Pregnant Women	2012	250

Notes - 2014
Pregnant and postpartum women qualify if <185% of poverty level.

Notes - 2014
Pregnant/ postpartum women, aged 8 - 18, qualify if 185% - 250% of poverty level.

Narrative:
Pregnant/postpartum women qualify for Medicaid if their income is <185% of FPL. Pregnant/postpartum women qualify for SCHIP if their income is between 185-250% of FPL. Parents of Medicaid or SCHIP-eligible children with incomes between 100% and 185% of FPL are eligible for SCHIP. Families with incomes >150% of FPL are subject to a family partial premium. The premium threshold increases to 185% for families consisting of only pregnant women and infant(s). /2013/ In Rhode Island, there is also state funded program for pregnant women with income between 251% and 350% of FPL. Under this program, which requires a premium, the state funds the cost of labor and delivery //2013//.

The DCFHE supports pregnant women's access to Medicaid through WIC, Childcare Support Network, the First Connections /2013/ and MIECHV Programs //2013//, and the adolescent health program, refer families who are uninsured or underinsured directly to Medicaid. All WIC applicants are screened for health insurance, and referred as needed to Medicaid.

/2013/ The Title X Family Planning agencies provide services to at-risk populations. The program identifies health risks among women and connects women to medical and community services, including RIte Care //2013//.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	1	No
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes

REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2014

Narrative:
The DCFHE links birth and infant death data from vital records on an annual basis. Birth data are also linked to WIC and newborn screening files. KIDSNET allows the DCFHE to also link birth data with newborn developmental risk screening, newborn hearing, immunization, lead screening, environmental inspections for children with elevated blood lead levels, early intervention, birth defects, foster care, and home visiting data.

The DCFHE has the ability to obtain data for program planning and policy purposes in a timely manner from the following registries/surveys: hospital discharge data for at least 90% of in-state discharges, PRAMS, and Birth Defects Surveillance. KIDSNET and OHHS have a signed data sharing agreement and are working to implement a plan to exchange data relevant to policy and planning. OHHS has developed a data warehouse which will greatly expand the capacity of DCFHE to access policy and program relevant data from OHHS and in the future can create the ability to obtain annual data linking birth certificates and Medicaid eligibility or paid claims files, electronically. Although the DCFHE does not necessarily need a direct link to Medicaid data (it has KIDSNET), it is exciting that the state is working on a data hub that will link OHHS data with education data. Piloting is currently taking place and it is anticipated that the data hub project will be completed in 2015.

WIC staff can now access KIDSNET immunization and lead screening data directly from the WIC Information System and print out lists of WIC clients needing these services. A pilot test of on-line referrals from primary care to city housing inspectors using KIDSNET was initiated. Participation and inspection data are available to the Asthma Program. CHDA/KIDSNET is part of an interagency effort working to develop and early childhood data system that links education, health, and other data under a National Governor's Association and Race to the Top initiative. Programming is underway to accept early childhood developmental screening scores in KIDSNET from Project Launch, primary care providers, home visitors, and other community partners that screen children. Development of on-line diagnostic reporting for newborn screening in KIDSNET has also begun. KIDSNET is working with health insurance companies to improve data on current insurance status of children. ***/2014/ The online asthma referral pilot project has been expanded to a third community. KIDSNET is working with RIDE to develop an on-line system for collecting and tracking Child Outreach development screening data as well as an exchange of roster data that will support vaccination coverage surveillance and outbreak response at the school level. A data book using GIS mapping of MCH data in KIDSNET is in development //2014//.***

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state	Does your MCH program have direct

	participate in the YRBS survey? (Select 1 - 3)	access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes
YRBS for Middle School	3	Yes

Notes - 2014

Narrative:

/2014/ Rhode Island participates in the Youth Risk Behavior Survey (YRBS) and the sample size is large enough for valid statewide estimates for this age group. Every two years, on the odd years, HEALTH conducts the YRBS from a statewide sample of 9-12th graders on past 30-day tobacco use, which is the measure for "current smoker". The DCFH participated in the development of RIDE's Surveyworks tool, a school-based survey that collects data ion youth wellness and risk behaviors. The same 30-day measure for tobacco use found on the YRBS is used by Surveyworks. By doing so, Surveyworks provides community-level data on past 30-day use of tobacco for 9th and 10th graders//2014//.

IV. Priorities, Performance and Program Activities

A. Background and Overview

Background and Overview

Results from the statewide needs assessment results, state and national performance measures, capacity indicators, and community stakeholders' input provide a comprehensive view of the MCH needs in Rhode Island. DCFHE identified state priorities and associated State Performance Measures from quantitative and qualitative information. The state priorities represent the four levels of the MCH pyramid and all MCH population groups. The capacity to address significant public health challenges at various service levels in an integrated way is a special mandate of Title V. DCFHE is proud of its coordinated, leveraged, and evaluated investments in community care for children and their families across the state.

For FY2011, the DCFHE developed new state priorities and State Performance Measures based on its comprehensive needs assessment and the community input received in FY2010. ***/2014/***
The nine (9) priorities were:

Priority: Increase capacity and access to evidence-based parent education and family support programs
Priority: Reduce tobacco initiation among middle school students.
Priority: Increase the percentage of adolescents who have a "well care" visit each year.
Priority: Increase the social and emotional health of children and youth with special health care needs.
Priority: Increase the percentage of women who have a preventive care visit in the last year
Priority: Initiate a prenatal home visiting program
Priority: Establish MOA with state departments that support maternal and child health related efforts
Priority: Promote use of evidence-based programs to support parents and families
Priority: Adopt social determinants of health into public health practice

In 2012, there were small revisions in State Performance Measure (SPM) 6 and 7 that provided clarity to the measures. In addition, the number of priorities was reduced from 9 to 7, however, the focus and intent of the priorities remained the same. Specifically, the priorities "establish MOA with state departments that support MCH related efforts" and "promote use of evidence-based programs to support parents and families" were discontinued. Rhode Island's Title V state priorities and SPMs for FY2014 will be the same ones used in FY2012 and FY2013, which are as follows //2014//.

Priority: Increase access and capacity to evidence based parent education and family support programs.
SPM1: Increase the number of RI resident families with at-risk newborns that receive a home visit during the newborn period (<=90 days).
SPM 7 Increase the number of parents with children in early childhood that enroll in evidence based parenting education/support programs.

Priority: Reduce tobacco initiation among middle school students.
SPM2: Reduce tobacco initiation among middle school students.

Priority: Increase the percentage of adolescents who have a preventive "well care" visit each year.
SPM3: Increase the percentage of insured adolescents who have a preventive "well care" visit each year.

Priority: Increase the social and emotional health of children and youth with special health care needs.
SPM 4 Decrease the percentage of high school students with disabilities who report feeling sad or hopeless.

Priority: Increase the percentage of women who have a preventive care visit in the last year.
SPM 5: Increase the percentage of women who have a preventive care visit in the last year

Priority: Initiate prenatal home visiting program.
SPM6: Increase the percentage of women delivering babies served by home visiting.

Priority: Adopt the social determinants of health into public health practice.
SPM 8: Decrease the number of Rhode Island adolescents who report food insecurity
SPM 9: Increase the number of Rhode Island high school students who earn a high school diploma or diploma equivalent in the six core cites.

SPMs 2-6 mirror the identified priorities reflected in the themes based on statewide data and community input. SPMs 1 and 7 are related priorities based on a life course approach for prioritizing health care needs and services by looking at health and wellness across the lifespan. The measures are for specific populations. Our intent and purpose is to have an overarching priority across all MCH population groups. SPMs 8 and 9 are indicators of the social determinants of health. Most health disparities affect groups that are disadvantaged or marginalized due to socioeconomic status, race/ethnicity, gender, sexual orientation, disability status, geographic location, or any combination of these. Access to healthy food and quality education are social determinants that contribute to good health.

These state priorities and corresponding performance measures, along with the 18 National Performance Measures are collectively designed to positively impact the six National outcomes measures including: (1) perinatal mortality, (2) infant mortality, (3) neonatal mortality, (4) postneonatal mortality, (5) child mortality, and (6) infant death disparity. The SPMs are short-term precursors for the National outcome measures. All six National outcome measures focus on mortality among our most vulnerable populations yet, within the context of State and National Performance Measures, the necessity and breadth of a life course approach is evident to reach these goals. Also, DCFHE's commitment and emphasis to include efforts across both the MCH and health equity pyramids, demonstrates our commitment to reduce disparities and achieve health equity for all Rhode Islanders.

/2014/It is important to illustrate how the DCFHE will be accountable for maternal and child health efforts supported by the Maternal and Child Health Block Grant. For the DCFHE, measuring progress toward successful achievement for each individual performance measure includes: budgeting and expending funds over the four levels of the MCH and health equity pyramids, positively impacting the six National outcome measures. The process used to identify MCH priorites for Rhode Island results in the establishment of strategies that address priority needs. In FY2014, Title V funds will be used to support the Center for Health Equity & Wellness (CHEW)Project, a health equity conference and grand rounds, Family Voices Rhode Island, the Parent Counsultant Program, the Pediatric Practice Enhancement project (PPEP), youth development and leadership training for YCHCN, the toll-free bi-lingual statewide Health Information Line, the distribution center for culturally and linguisticall appropriate printed informational materials, the BRFSS (six child-related questions), TWOS, PRAMS, the Asthma Health Resources & Action Program, pediatric oral health services, the evidence-based Teen Outreach Program (TOP), and Ready to Learn Providence //2014//.

B. State Priorities

State Priorities

This section describes the relationship of the State priorities, National and State performance measures along with the capacity and resource capability of HEALTH's DCFHE, as the State Title V administrator. This discussion pertains to the new State priorities and performance measures developed in /2013/ 2011 //2013// and revised in 2012 ***//2014//.***

DCFHE uses a life course development approach that addresses the determinants of health as its framework for health planning. Social, political, and economic policies and conditions evolve and determine health outcomes. While HEALTH has made significant progress in meeting Title V measures and Healthy People 2020 goals, disparities still exist. Therefore, proactive and applied public health strategies focus on all members of the community to eliminate health disparities in Rhode Island. It is through this collective work effort that DCFHE offers quality programs and continues to assure that all Rhode Islanders will achieve optimal health throughout the lifespan via a statewide system of services that are comprehensive, community-based, coordinated and family-centered. This approach links with the MCH needs assessment and program narrative to form the basis of our work in this application.

State priorities were developed in /2013/ 2011//2013// as part of the five-year needs assessment. /2013/ A few of the priorities (3, 6, 7) were refined in 2012 //2013//. All nine state priorities address significant needs identified through data analysis and community input. The DCFHE has assessed internal capacities as well as external resources to meet these needs. State Performance Measures were developed for each of the new priorities, along with a statement of significance for each measure. Where appropriate, selected example activities under each priority will address each level of both the MCH and Health Equity pyramids as discussed in detail in the Needs Assessment. Attention to each level of the pyramid ensures that individual; family/community; and systems needs are addressed to create healthful environments to support maternal and child health. In addition, many of the state priorities directly relate to the National Performance Measures.

Priority: Increase access and capacity to evidence-based parent education and family support programs.
SPM1: Percent of RI resident families with at-risk newborns that receive a home visit during the newborn period (<=90 days). Related National Performance Measures include: 1, 12, 15, 17, 18.

This measure is the former State Performance Measure 3 revised to reflect the expanded home visiting efforts in RI /2014/ though the MIECHV Program in the Affordable Care Act //2014//. There are gaps in services for families with young children to provide parent education and family support. These are needed to improve outcomes.

/2014/This priority is in both the infrastructure and systems building and social determinants of health level of the MCH and Equity pyramids. Evidence-based home visiting programs focus on improving the well-being of pregnant women and families with young children. Empowered and informed parents can have a better understanding of their child's healthy growth and development and can better work to change the contest of their health choices as the default option. In 2012, the MIECHV Program implemented Healthy Families America in six communities, expanded the capacity of Nurse Family Partnership to provide services in three additional communities and expanded the capacity of Parents As Teachers in four communities. These three programs work in collaboration with the statewide First Connections home visiting program to provide home visiting services to families with newborns at risk for poor outcomes.

Through the Race to the top Early Learning Challenge Grant, HEALTH and RIDE will support primary care providers to provide or link their patients to evidence-based parent

education and family support programs. Through Project Launch, the evidence-based Incredible Years Parenting Program is being offered at Launch's partner child care sites. Parent leaders have also been trained at various locations. HEALTH is also working to engage 3rd party payers to reimburse for Incredible Years groups and to establish billing practices //2014//.

Priority: Reduce tobacco initiation among middle school students.
SPM2: Percent of middle school students who have initiated tobacco use. Related National Performance Measures include: 5, 13, 15.

The tobacco industry is losing its customer base as adults quit smoking and/or die of smoking related illnesses. To ensure a steady stream of tobacco users, tobacco companies target young people with very seductive marketing campaigns. Prevention of youth initiation will ensure fewer youth will become addicted to tobacco in adulthood.

The priority is in both the infrastructure building and social determinants of health portion of the pyramid. Strategic policy development can eliminate access to tobacco for minors. Additionally, population based services like health education can inform youth about tobacco and create environments where healthy choices are the default choice. Direct health care services and education and counseling could include the development of evidence-based approaches to support youth who have initiated tobacco use already.

Priority: Increase the percentage of insured adolescents who have a preventive "well care" visit each year.
SPM3: Percent of insured adolescents who have a preventive "well care" visit each year. Related National Performance Measures include: 2,3,4,5, 6,8,10,13,16.

Rhode Island has a low rate of uninsured children including adolescents. This measure includes only adolescents enrolled in health plans however, children who are not insured most likely do not receive preventive care. Health plans in RI report HEDIS measures including adolescent well care visits for their enrolled populations. Even though, only 7% of Rhode Island's children under age 18 were uninsured between the time period of 2006-2008, approximately 40% of adolescents did not receive a well care visit in the previous year as per the HEDIS measure. There was no difference between private and public health insurance plans in terms of adolescent well care visit. The HEDIS national benchmark measure for adolescent well care visits is under 60%, which may explain why the health care utilization for adolescent well care is not better.

This measure effects all levels of both pyramids as health insurance can provide access to care yet it does not guarantee that adolescents will utilize the care. Direct health care such as provider practices (e.g. adolescent friendly, wellness promotion/risk reduction versus traditional visit), enabling services such as health plan incentives (e.g. use of services by enrolled members), population based services such as youth and parent engagement strategies (support for visit, and how it aligns with adolescent developmental needs) as well as infrastructure building policies (such as required physical for high school and a more rigorous HEDIS measure) to increase the number of adolescents receiving well child visits needs to be considered to develop supportive systems of care for adolescents thereby addressing social determinants of health.

/2013/ The DCFHE developed a report on Access to Care for Adolescents that includes a literature review on the state of adolescent health care access, quantitative data, a qualitative analysis of RI adolescent health access and system development recommendations. An adolescent health summit this fall will engage stakeholders' commitment to implement the recommendations //2013//.

2014/ In 2013, the Immunization Program contracted with a physician for QI initiatives in pediatric providers offices to improve adolescent vaccine rates using KIDSNET. The Immunization Program received the CDC Adolescent Coverage Award for achieving top tier rates of 84.4% for

the adolescent immunization series, including Tdap, Meningococcal, and HPV ***//2014//.***

Priority: Increase the social and emotional health of children and youth with special health care needs.
SPM 4 Percent of high school students with disabilities who report feeling sad or hopeless. Related National Performance Measures include: 2, 3, 4, 5, 6.

The behavior risk status of RI's youth with special needs is of great importance to state and local policy leaders from health, education, human services, and juvenile justice. Data from the YRBS indicate that students with disabilities are more likely to start earlier and currently smoke cigarettes, drink alcohol, and use marijuana; more likely to be threatened, physically fight, be forced to have sex, and not go to school due to feeling unsafe; more likely to get insufficient physical activity and more likely to be overweight. Further, students with disabilities are more likely to report feelings of hopelessness and to consider and attempt suicide than their non-disabled peers. Although many students in RI participate in risky behaviors, the data indicate that students with disabilities participate in these behaviors earlier, more consistently, and to a more dangerous level than their peers. The OSHCN in the Health Disparities and Access to Care Team leads the charge in highlighting the risk behaviors of students with disabilities and systematically addressing them through the levels of the MCH and Equity pyramids by increasing the following: infrastructure building services such as well-integrated academic interventions; enabling services such as positive social and recreational activities; populations and individual based education and counseling programs that support self-determination and student leadership; and direct health care interventions that address behavioral health concerns.

Priority: Increase the percentage of women who have a preventive care visit in the last year.
SPM 5: Percent of women who have a preventive care visit in the last year. Related National Performance Measures include: 6, 8, 15, 16, 18.

This priority is expected to improve health outcomes by improving the focus on prevention, reducing the likelihood of developing a chronic disease, and increasing utilization of primary care as women establish a relationship with a primary care provider. This may also reduce health care costs by reducing utilization of the emergency department for preventable conditions.

The Women's Health Advisory Committee advises HEALTH's Office of Women's Health on statewide priorities and policies to address social determinants of health as well as build infrastructure to support women's health. It envisions a RI where women live to their optimal level by achieving an ideal state of health by promoting a gender-informed, coordinated, comprehensive, primary prevention approach to women's health across the lifespan. Work is targeted to eliminate health disparities across all dimensions of age, ability, geography, race, ethnicity, sexual orientation, economics and education. Enabling services for children and families can assist women in accessing necessary care. Accessing direct health care services and clinical interventions can ensure all women are able to achieve optimal health.

/2014/ The three evidence-based home visiting programs implemented through the MIECHV Program work with enrolled women to ensure that they are linked to a medical home. They work to ensure that new mothers attend their postpartum appointment and empower them to talk to their health care provider about their health //2014//.

/2013/ Also, the RI Task Force on Premature Births made recommendations addressing all levels of the MCH and healthy equity pyramids including: meeting the state's standards for comprehensive family life and sexuality education in schools, supporting state policies and programs that ensure access to comprehensive primary and preventive health care services for

women, expanding the range of services in all settings where women receive health care to include improved assessment and identification of health risks, health information, and referrals for health risks associated with preterm birth, and enhancing comprehensive, relationship family support programs to improve outcomes for women and their children and prevent subsequent teen pregnancy //2013//.

Priority: Initiate prenatal home visiting program.
SPM6: Percent of pregnant women determined to be at risk for poor outcomes, residing in selected communities who receive a home visit during the prenatal period. Related National Performance Measures include: 4, 5, 8, 11, 12, 13, 14, 15, 17, 18.

RI has high rates of prematurity and low birth weight rates, as well as, high rates of infant mortality in participating core cities. RI has limited home visiting capacity to serve pregnant women using an evidence-based model.

/2014/ The statewide First Connections Home Visiting Program offers visits that provide direct health care, education and counseling, through four community based agencies. Over 60% of families with newborns who have specific risk profiles created from information collected at birthing hospitals are offered First Connections services. Home visitors provide general parenting information, conduct home assessments, educate parents about infant care, and link families to appropriate resources. DCFHE is implementing prenatal home visiting through evidence-based home visiting models such as HFA, NFP, and PAT as well as prenatal home visiting through First Connections in an effort to build a strong infrastructure for home visiting as well as to inform polices that affect the social determinants of health for participating families served. Through the MIECHV Program in the Affordable Care Act, MIECHV has implemented 3 evidence-based home visiting programs; all of which target prenatal women for enrollment. These programs work with women to ensure that they attend their recommended prenatal visits per the Kotelchuck index, have a healthy pregnancy, and adopt a healthy and safe lifestyle //2014//.

Priority: Increase access and capacity to evidence based parent education and family support programs.
SPM 7: Number of parents with children in early childhood that enroll in evidence based parenting education/support programs. Related National Performance Measures include: 1, 2, 4, 7, 9, 11, 12, 13,14, 15, 17.

This priority is overarching across all of the MCH population groups although the measure is specific to early childhood. More evidence-based programs that demonstrate outcomes are needed to ensure that resources are allocated to programs that improve outcomes. Evidence based programs can address the social determinants of health by building the knowledge and skills of parents to address their families' needs. Additionally evidence based program approaches can help inform policy development to strengthen the State's capacity and infrastructure to support families. ***/2014/ Through the MIECHV Program, evidence-based home visiting services are provided in six communities //2014//.***

Priority: Adopt the social determinants of health into public health practice.
SPM 8: Percent of Rhode Island adolescents who report food insecurity. Related National Performance Measures include: 5, 9, 11, 13, 14, 17, 18.

Food insecurity is a proxy measure for poverty. Income is a social determinant of health status. McDonough et al. used data from the Panel Study of Income Dynamics for the years 1968 to 1989; they used fourteen ten-year panels to analyze predictors during the first five years and vital indicators during the second five years of each panel. They found that "Income level was a strong predictor of mortality, especially for persons under the age of 65" and they concluded that "income and income stability should be addressed in population health policy" (McDonough et al.,

1997, p. 1476).

This priority is overarching across all MCH populations and reflects a life course perspective. Direct health care and education can help inform healthy nutritional choices and advocacy for access to healthful choices. Enabling services such as transportation can help ensure access. Policies that limit access to unhealthy food and increase access to healthy choices create an infrastructure that support health practices as the default choice.

Priority: Adopt the social determinants of health into public health practice.
SPM 9: Percent of Rhode Island high school students who earn a high school diploma or diploma equivalent in the six core cites. Related National Performance Measures include: 2, 3, 4, 5, 6, 8, 9, 10, 12, 13, 14, 15, 16, 17, 18.

Grossman and Kaestner cite a number of studies (Auster et al., 1969; Grossman, 1972; Grossman, 1975; Grossman & Benham, 1974; Silver, 1972) that suggest, "years of formal schooling completed is the most important correlate of good health" (Grossman & Kaestner, 1997, p. 73). Their examples show schooling to be a more important determinant of health than income or occupation, and this holds true when controlling for the reverse causality occurring when poor health leads to poverty.

This priority is overarching across all MCH populations and reflects a lifecourse approach. The interrelationship between health and academic achievement is cyclical. Children who come to school ready to learn become children who leave school ready to lead productive lives, which is why increasing the high school graduation rate to 90% is an official health objective for the nation for the year 2010 (U.S. DHHS, 2006). Children who are healthy can learn better. Children who enjoy learning are more likely to stay in school. Children who stay in school have better health outcomes in their adult lives. Adults who practice healthful behaviors can teach children the value of a healthy lifestyle (Bogden, 2003). School and community based efforts, along with the development of polices and systems of care will address every level of the MCH and Equity pyramids to ensure positive health outcomes across the MCH populations.

/2013/ The new federal Race to the Top's collaborative emphasis on the link between health and education in early childhood is an important step in supporting this link across the lifespan. Additionally, the emphasis of chronic absenteeism, as a Race to the Top indicator, demonstrates the measures' relationship to both health and education outcomes. The measure has fostered conversations among broad groups of health and education professionals on how health and education systems can work together for RI's school-aged youth. DCFHE collaborated with RI Kids Count on a data brief regarding health disparities and social determinants of health including graduation from high school //2013//.

Priorities, Capacity and Resource Allocation

After the development of the priorities, activities and projects are identified to address the priority strengths and needs through the Venture Capital Request (VCR) process. The VCR's describes the activity or project and includes required MCH information on how the VCR aligns with one or more of the set priority or priorities, type of population and type of service data, how the VCR will be measured and how it aligns with the application process or measures.

In addition, VCR reflects the four pillars of the DCFHE's approach for public health: health equity, the social and environmental determinants of health, the life course approach and integrations of programs. MCH Block grant resources are allocated based on the interventions from the health equity framework. This ensures that Federal MCH Block Grants funds are utilized to improve maternal and child health, reduce disparities and achieve health equity for all Rhode Islanders. DCFHE, as the designated Title V administrator for RI, looks forward to developing capacity and expertise to address these priorities and measures over the next five years.

/2013/ DCFHE's Office of Minority Health (OMH) will continue to support the Community Health Worker Association of Rhode Island (CHWARI) to support racially and ethically diverse community activation around integrative public health, including MCH, efforts. Local support and outreach programs such as PPEP, family resource counselors, Americorp Volunteers, and Life Span Community activists are included in the CHWARI system, which includes career ladders, core competency training, and CHW certification.
OMH will continue to educate community partners on the social and environmental determinants of health though quarterly "Equity Dialogues" targeting youth, tribal communities, Southeast Asian populations, and LGBT persons of color. The OMH will staff and support the Commission for Health Advocacy & Equity by working with the Commission to set goals for health equity and to prepare a plan for Rhode Island to achieve health equity in alignment with other statewide planning activities. OMH, through the Commission, educates state agencies on health disparities, including social factors that play a role in creating and/or maintaining these disparities. OMH helps to support the preparation of biennial disparities impact and evaluation reports.

/2014/ OMH distributed over 10,000 "I Speak" cards in RI's top three languages in addition to 7 of RI's top refugee languages letting patients know about their rights to a qualified and competent medical interpreter to CBOs and minority communities; conducted presentations on federal CLAS standards to all DCFHE teams, CHDA, RIPIN, and Youth Works, and ambulatory care facilities; and developed boilerplate language on CLAS standards that is attached to all HEALTH community contracts. During the upcoming year, OMH will continue to supply "I Speak" cards in 10 languages, draft revisions to the medical interpreter sections of the state's hospital regulations, and monitor, track, and document language violations by health care providers through consumer complaints //2014//.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 495 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	99.6	99.6	99.6	99.6	100
Annual Indicator	100.0	100.0	96.0	100.0	100.0
Numerator	37	27	24	35	34
Denominator	37	27	25	35	34
Data Source	Newborn Screening Blood Spot DB	Newborn Screening Blood Spot DB	Newborn Screening Blood Spot DB	Newborn Screening Blood Spot DB	Newborn Screening Blood Spot DB
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5					

and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	100	99.9	99.8	99.8	99.9

Notes - 2010
2010: Of the 25 infants screened positive and needing treatment, 24 received appropriate follow up. One family moved out of state prior to treatment.

a. Last Year's Accomplishments
Data Discussion:
Annual data shows that Rhode Island continues to maintain high levels of newborn screening and follow up. /2013/ All newborns receive a newborn bloodspot screen prior to hospital discharge. //2013//. ***/2014/ Data for 2011 shows that 100% of babies born with a positive screen, including babies born at home, received timely follow up to a confirmatory diagnosis //2014//.*** /2013/The state has put quality assurance systems in place and policies and procedures to ensure that all newborns receive a newborn screening, diagnosis, and treatment services as soon as possible after a positive screen. Ensuring these high rates of screening and follow up is a high priority for the Newborn Screening Program //2013//.

a. Last Year's Accomplishments

/2013/ The DCFHE through the Newborn Screening Program continued to provide universal newborn screening for the 29 core disorders, including hearing impairment, developmental risk, and secondary conditions that can be detected in the diagnosis of core disorders. The Newborn Screening Program continued to assure screening, diagnosis, and treatment services for all newborns born in the state for the disorders screened.

The Newborn Screening Program continued to track all abnormal screenings to resolution of findings through confirmatory testing and initiation of treatment. This includes maintaining contracts with the New England Newborn Screening Laboratory in Massachusetts for the analysis and storage of bloodspots, the VNA of Care New England for tracking and follow-up of bloodspot results, and with Rhode Island Hospital ***/2014/ clinics for diagnosis and treatment of infants identified through bloodspot screening. The DCFHE continued to assure that newborns with developmental risks received appropriate follow-up care through the First Connections Program. In addition, the First Connections Home Visiting Program provided outreach services to families who were difficult to reach //2014//.***

/2013/ A Continuous Quality Improvement (CQI) plan for bloodspot newborn screening continued. The CQI Plan includes quality assurance site visits at the seven birth hospitals, data and system level quality issues, and ongoing review of policies and procedures by the Newborn Screening Advisory Committee. This Committee advised the Newborn Screening Program on strategic planning, policies and procedures, new conditions to be added to the RI newborn screening panel, and associated services. Members include health care providers, representatives from the March of Dimes, public health experts, and people involved in delivering services, follow-up, and treatment in the state. The Rhode Island Newborn Screening Advisory Committee continued to meet on a bi- monthly basis.

The Newborn Screening Program continued to use KIDSNET to identify true missed specimens, delayed specimens, and other important systems issues, which were addressed at the hospital level. Condition-specific reporting guidelines for the RI system are in development and will

document reporting and follow-up processes for program staff //2013//.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided universal newborn screening for 29 core disorders including hearing impairment, developmental risk, and secondary conditions that can be detected in the diagnosis of core disorders.			X	
2. Assured newborn screening, daignosis, and treatment services for all newborns born in the state for the disorders screened and tracked all abnormal screenings to resolution of findings through confirmatory testing and initiation of treatment.			X	
3. Provided home visiting services to families who are hard to reach through First Connections.	X			
4. Maintained a CQI Plan for bloodspot newborn screening that includes ongoing review of policies and procedures by the Newborn Screening Advisory Committee.				X
5. Used KIDSNET to identify true missed specimens, delayed specimens, and other important systems issues to be addressed at the hospital level.				X
6. Maintained a newborn screening fee to support the newborn screening system.				X
7. Worked to ensure that all newborns born at home receive both a hearing and bloodspot screening.	X			
8. Distributed informing brochures to families in English and Spanish and utilize PRAMS to monitor the impact of these efforts.		X		
9. Worked with the Newborn Screening Advisory Committee to evaluate the feasibility of adding new conditions such as Severe Combined Immunodeficiency Disease and Critical Heart Disease to the newborn screening panel.	X			
10.				

b. Current Activities

/2013/ DCFHE continues to implement the activities described in last year's accomplishments section. Severe Combined Immunodeficiency Disease (SCID) and Critical Congenital Heart Disease (CCHD) have been recommended for inclusion to the panel. DCFHE, the New England Genetics Collaborative, and other New England states was awarded a grant for a regional CCHD demonstration project to enhance existing networks among state public health departments and birthing facilities, to share resources and expertise in developing CCHD Disease screening protocols, developing educational materials and program evaluation //2013//. ***/2014/ 3 of the 6 birthing hospitals in RI are piloting pulse oximetry screening to assess the screening of all RI newborns for CCHD prior to birthing hospital discharge. The goal is to expand screenings to all RI birthing hospitals and home births //2014//.***

/2013/The AAP recently expanded its recommendations for reducing the risk of sudden, unexpected infant death to focus on a safe sleep environment that can reduce the risk of all sleep-related infant deaths, including those from SIDS. In response, the Newborn Screening Program is leading an effort to promote safe infant sleep practices among expecting and new parents and caregivers. ***/2014/ HEALTH's Newborn Screening Program developed key safe sleep messaging, based on new recommendations //2014//.***

c. Plan for the Coming Year

/2014/ DCFHE will continue to implement the activities outlined in last year's accomplishments and current activities sections. KIDSNET will provide an online mechanism for RI specialty clinics to report newborn diagnoses, test results and treatment methods for infants with a confirmed newborn screening condition. Programming in KIDSNET is underway to allow on-line diagnostic reporting for newborn screening blood spot conditions. Newborn Screening results and needed follow-up are currently available in KIDSNET. Results of newborn CCHD screening will be available soon to primary care providers through KIDSNET as well. DCFHE will continue to evaluate adding new conditions such as SCID and CCHD to the panel.

DCFHE will continue to lead an effort to promote safe infant sleep practices among expecting and new parents and caregivers. The Newborn Screening Program will participate in the NCC/RC LTFU data work group partnered with the NBSTRN Clinical Centers work group to develop uniform long term follow up on data sets for the longitudinal capture of health information for conditions that are part of routine newborn screening. For the Sleep Safe Campaign, home visitors and WIC agencies are two avenues that are being targeted to promote the safe sleep campaign and work directly with families //2014//.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**11652**					
Reporting Year:	**2012**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	11636	99.9	0	0	0	
Congenital Hypothyroidism (Classical)	11636	99.9	18	9	9	100.0
Galactosemia (Classical)	11636	99.9	5	2	2	100.0
Sickle Cell Disease	11636	99.9	6	6	6	100.0
Biotinidase Deficiency	11636	99.9	1	0	0	
Cystic Fibrosis	11636	99.9	8	8	8	100.0

Homocystinuria	11636	99.9	1	0	0	
Maple Syrup Urine Disease	11636	99.9	0	0	0	
Congenital Adrenal Hyperplasia (CAH)	11636	99.9	2	0	0	
beta-ketothiolase deficiency	11636	99.9	1	0	0	
Tyrosinemia Type I	11636	99.9	1	0	0	
Galactosemia	11636	99.9	5	2	2	100.0
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	11636	99.9	3	0	0	
Citrullinemia	11636	99.9	1	1	1	100.0
Isovaleric Acidemia	11636	99.9	0	0	0	
Propionic Acidemia	11636	99.9	0	0	0	
Carnitine Uptake Defect	11636	99.9	0	0	0	
3-Methylcrotonyl-CoA Carboxylase Deficiency	11636	99.9	0	0	0	
Multiple Carboxylase Deficiency	11636	99.9	0	0	0	
Trifunctional Protein Deficiency	11636	99.9	0	0	0	
Glutaric Acidemia Type I	11636	99.9	1	0	0	
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	11636	99.9	1	1	1	100.0
Long-Chain L-3-Hydroxy Acyl-CoA Dehydrogenase Deficiency	11636	99.9	1	0	0	
Methylmalonic Acidemia (Mutase Deficiency)	11636	99.9	2	0	0	
S-Beta Thalassemia	11636	99.9	0	0	0	
Sickle/Hemoglobin C Disease	11636	99.9	0	0	0	
Non-Sickling Hemoglobin Disease	11636	99.9	7	7	7	100.0
Glutaric Acidemia Type 2	11636	99.9	0	0	0	
Hydroxmethlglutaric acidurial/HMG-CoA lyase def (HMG)	11636	99.9	0	0	0	

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	61.4	61.4	61.4	63	75.5
Annual Indicator	61.4	61.4	61.4	75.5	75.5
Numerator					
Denominator					
Data Source	CSHCN survey	CSHCN survey	CSHCN survey	CSHCN survey	CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	75.5	75.5	78.5	78.5	78.5

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments

Data Discussion
/2013/ According to data from the 2009/2010 National Survey of CSHCN, 75.5% of families of CSHCN reported they are partners in shared decision making for their child's optimal health. Although the indicator is not comparable across survey years, the family partnership measure in 2005/2006 NS-CSHCN was 61.4%. RI remains significantly higher than the national average of 70.3% //2013//. ***/2014/ Rhode Island awaits the release of the new NS-CSHCN data //2014//.***

OSHCN, in coordination with the RI Family Voices Program located at RIPIN, made resources available to parents of CSHCN and the professionals working with them. OSHCN has made available the RI Resource Guide for Families of Children with Autism Spectrum Disorders (English and Spanish), RI Resource Guide for Families of Children who are Deaf or Hard of Hearing, the Complete Care Notebook, Family Voices Resource Guide, RI Resource Guide to Mental Behavioral Services & Supports, /2013/ and the Ready Set Go Series for Adolescent Healthcare Transition //2013//. All of these materials were disseminated to parents and professionals to drive best practice in the diagnosis and treatment of CYSHCN.

/2014/ The PPEP was expended in 2012 to an additional 6 pediatric primary care practices and 4 pediatric specialty sites to a total of 40 PPEPS to foster the communication and partnership between parents and providers. These additional sites were targeted for serving high numbers of CSHCN through the CEDARR program. The sites will receive a 5 hour per week parent consultant who will link families with necessary community-based services/supports while assisting the practice in implementing the CMS health home CEDARR model //2014//. Through the PPEP and Family Voices of RI, parent leaders have been cultivated and supported to lead policy initiatives, make systems improvements and champion principles of parent-professional partnerships. Through the Family Voices Leadership Team, OSHCN addressed systems barriers to a coordinated service delivery system and developed a parent policy team to provide peer-to-peer support in addressing statewide policy, especially health reform. ***/2014/ Over eighty-five family members //2014//*** have been trained on public policy, meet on an ongoing basis to discuss pending legislation, and prepare written and spoken testimony.

/2013/ The Parent/Professional partnership Conference held in March 2011, focused on the changing system of care for CSHCN in RI and included presentations and exhibits on a full range of health, education, mental health, child welfare, financing, and transition topics. The conference offered local and national speakers and attracted nearly 250 RI parents and professionals //2013//.

The OSHCN partnered with the Autism Project of RI to inform and support families in accessing best practice evaluation and treatment for their children with an Autism Spectrum Disorder (ASD) or other Developmental delays (DD). ***/2014/ Nearly 800 families networked with other families to reduce isolation and develop resiliency in parenting their children //2014//.***

HEALTH took the lead in establishing a Family Leadership Development Institute (FLDI) to develop a network of family leaders in RI to make a positive impact on schools, communities and in health care arenas. Parent education and workshop sessions are provided through the RIPIN, Parent Support Network and Sherlock Center for Disabilities. /2013/ Through this collaboration, 50 families participated in the Agents of Transformation Training that educated parent mentors in accessing the children's welfare and children's mental behavioral health system. There were over 500 parents and professionals trained in navigating the special needs service delivery system such as basic rights, college success for students with disabilities, options for medical assistance, policy 101, transition planning, etc. //2013//.

Parent support groups are organized throughout the state and HEALTH contracted with RI's Family Voices to maintain a master calendar of support groups based on topic, age, and language. Parent consultants educated and empowered families in the Early Intervention Program, PPEP, WIC, Birth Defects, Immunization, Community Asthma, Distribution Center,

Emergency Preparedness, TBI, and Health Information Center.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided ongoing dissemination of family-centered materials and resource guides.		X		
2. Placed trained parent consultants in pediatric primary care & speciality care settings throughout RI through PPEP to help families navigate the system of services for CYSHCN.	X			
3. Trained parent consultants and supported their participation in advisory and planning committees impacting CYSHCN.		X		
4. Convened a statewide CYSHCN conference for parents of CYSHCN and the professionals who work with CYSHCN and their families.		X		
5. Provided ongoing support to parents through the FLDI.		X		
6. Supported RI Family Voices to maintain a master calendar of support groups for CYSHCN and their families.		X		
7. Supported parent consultants to continue to education and empower families in CYSHCN programs.		X		
8.				
9.				
10.				

b. Current Activities

/2013/ DCFHE continues to make resources available to parents of children with special healthcare needs and the professionals working with them, promote family-centered care and parent consultant services through the PPEP, address systems barriers to a coordinated service delivery system and continues to maintain a parent policy team to provide peer-to-peer support in addressing statewide policy, provide parents of CSHCN with training opportunities to prepare them for participation on advisory and planning committees, provide parents of CSHCN with training opportunities to prepare them for participation on advisory and planning committees, partner with the Autism Project of RI, support the FLDI, maintain a master calendar of support groups, support the Parent/Professional partnership Conference, partner with RI Family Voices and the RI Family Voices Leadership Team to empower families and youth through education, peer-to-peer support, skill building and leadership development.

/2014/ As Rhode Island implements the Affordable Care Act, significant emphasis is placed on consumers understanding available health care options for themselves and their children. RIPIN, the home of Family Voices and the vendor of PPEP, is contracting with the Office of the Health Insurance Commissioner for Rhode Island's Marketplace Consumer Assistance Program //2014//.

c. Plan for the Coming Year

The DCFHE will continue to include consumer voices (including parents of CYSHCN) in all levels of program development and implementation. The OSHCN will continue to ensure that families with CYSHCN are engaged in program planning, implementation, and evaluation and that families are full partners in the development of policy affecting their lives and the lives of their children through distribution of materials within pediatric practices, involvement in the Global Compact Medicaid Waiver Workgroups and Family Voices Leadership Team. In addition, the

DCFHE will continue to seek an increase in satisfaction among consumers through qualitative and quantitative evaluation of its programs and initiatives.

The OSHCN will continue to assess the need in the community for additional resource guides and distribute them to families and professionals. The OSHCN will continue to make available the RI Resource Guide for Families of Children with Autism Spectrum Disorders (in English and Spanish), the RI Resource Guide for Families of Children who are Deaf or Hard of Hearing, the RI Complete Care Notebook, the Adolescent Healthcare Toolkit, the RI Family Voices Resource Guide, the RI Resource Guide for Behavioral Health Services and Supports and the Youth Transition Workbook.

The OSHCN will continue to promote family-centered care and parent consultant services through the PPEP. The PPEP will continue to work with funders, insurers and state leadership on the demonstrated impacts of the PPEP model of service delivery. The OSHCN will continue to provide technical assistance within the state and to other states regarding the engagement of consumers in all aspects of decision-making and its importance in the health care reform debate. Through the Family Voices Leadership Team, the OSHCN will address identified systems barriers to a coordinated service delivery system. The OSHCN will provide opportunities to demonstrate parent professional partnerships including an annual conference, policy meetings and ongoing committees.

The DCFHE will continue to support the development of a comprehensive system of family leadership through the FLDI. The DCFHE will continue to monitor the health reform roll-out for CYSHCN and other vulnerable populations.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(ii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	50.9	50.9	50.9	55.5	44
Annual Indicator	50.9	50.9	50.9	44	44
Numerator					
Denominator					
Data Source	CSHCN survey	CSHCN survey	CSHCN survey	CSHCN survey	CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	44	44	46.5	46.5	46.4

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001

CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

a. Last Year's Accomplishments
/2013/ Data from the 2009/2010 National Survey of CSHCN indicate that 44% of CSHCN received coordinated, ongoing and comprehensive care within a medical home. RI's data remains above the national average of 43%. There was a significant decrease from 2005/2006 NS-CSHCN data of 50.9%. //2013//. ***/2014/ However, data is not comparable across years //2014//.***

The DCFHE's OSHCN worked to increase the number of CYSHCN in RI who have a medical home by partnering with PPEP, EOHHS (on CEDARR, EPSDT, and Medicaid policy), Health Plans, the RI Chapter of the American Academy of Pediatrics, the Academy of Family Physicians, and the Society of Adolescent Medicine //2013//.

The PPEP -- a medical home enhancement project -- was expanded to include several community based organizations and specialty service providers. The Family Voices Leadership Team addressed barriers identified through the PPEP to a coordinated service delivery system and partnered with health plans to identify and reimburse medical home-type services. The DCFHE worked with RI health plans on appropriately reimbursing practices that provide a comprehensive medical home.

/2013/ PPEP parent consultants in the Neonatal Intensive Care Unit (NICU) at Women & Infants Hospital, the Ventilator Integration Program at Hasbro Children's Hospital and the Neonatal Follow-up Program provided medical home services to infants and toddlers with complex medical conditions.

The OSHCN supported a Peer Resource Specialist position at the RI Hospital Transition Clinic, which provides medical home and transition services to YSHCN //2013//.

The OSHCN participated on the CEDARR Interdepartmental Team, assisted /2013/ EOHHS //2013// in reprocurring the State's Medicaid Managed Care Contract, was engaged in distributing RI's EPSDT Schedule, supported existing medical home systems development in the communities of Newport, Washington County, Mt. Hope, and Pawtucket/Central Falls. /2013/ Further, the OSHCN partnered with EOHHS in transitioning the CEDARR program to a CMS Health Home based on federal permission in the fall of 2011. The OHHS/HEALTH Team presented the model of collaboration nationally and actively provided TA to other states.

The DCFHE continued to provide TA to Washington County and Woonsocket CATCH partners on the development of medical homes, pediatric behavioral health services, and prenatal care for hard-to-reach populations. The DCFHE and its Woonsocket CATCH partners utilized a model report of adolescent medical homes to develop and implement strategies to improve health outcomes //2013//.

HEALTH's Center for Health Data and Analysis (CHDA) gathered data and determined the percent of RI children with medical homes.

The OSHCN partnered with the Chronic Disease Team on workforce capacity to support the medical home, including /2013/ parent consultants, resource specialists, peer navigators //2013//, asthma educators, diabetes educators, Living Well Self-Management programs, cancer peer navigators, and cardiovascular disease educators.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Worked to increase the number of CYSHCN who have a medical home by partnering with other orgnizations and programs.				X
2. Supported the PPEP and is working to include PPEP in Rhode Island's health care reform efforts.				X
3. Assisted OHHS in implementing an enhanced medical home focus within its care coordination CEDARR program that was awarded CMS Health Home Status.				X
4. Supported PPEP parent consultants in the NICU at Women & Infants Hospital and the Ventilator Integration Program at Hasbro Children's Hospital and Neonatal Follow-Up Program.		X		
5. Collaborated with Family Voices Leadership Team to address systems barriers to a coordinated service delivery system & participated on the CEDARR Interdepartmental Team overseeing RI's care coordination system for CYSHCN				X
6. Supported CHDA to gather data and determine the percentage of RI's CYSHCN with a medical home.		X		
7. Partnered with the Chronic Disease Team on workforce capacity to support the medical home.		X		
8. Supported the replication of the Harlem Children's Zone's Asthma Initiative in lower South Providence		X		
9.				
10.				

b. Current Activities

/2013/ OSHCN continues to work to increase the number of CYSHCN who have a medical home by partnering with PPEP, EOHHS (on CEDARR, EPSDT, and Medicaid policy), health plans, the

RI-AAP, the RI-AFP, and the SAM.

OSHCN and partners are working to include PPEP in RI's Health Reform efforts. A Peer Navigator model (based on the PPEP) is being supported through Medicaid Managed Care for high ED users.

OSHCN assists EOHHS in implementing an enhanced medical home focus within its care coordination CEDARR program. OSHCN supports the training and implementation of the CMS Innovations Challenge Grant with the WIH Program for medically complex CSHCN.

PPEP parent consultants continue to provide medical home services to infants and toddlers with complex medical conditions.

OSHCN collaborates with Family Voices to address the systems barriers to a coordinated service delivery system; participates on the CEDARR Interdepartmental Team overseeing RI's care coordination system for CYSHCN; and supports the preventative and screening functions of the medical home through RI's revised EPSDT Schedule.

CHDA continues to gather data and determine the percent of CSHCN with medical homes. OSHCN continues to partner with the Chronic Disease Team on workforce capacity to support the medical home //2013//.

/2014/The DCFHE's Title V-funded CHEW project includes replication of the Harlem Children's Zone's Asthma Initiative in lower South Providence through FSRI //2014//.

c. Plan for the Coming Year

/2013/ The DCFHE will continue to work to increase the number of CYSHCN in RI who have a comprehensive medical home. To accomplish this, the DCFHE will continue to improve and expand its current programming through PPEP as well as partner with state and community agencies, including EOHHS (on CEDARR and other initiatives), the RI Chapter of the American Academy of Pediatrics, the Academy of Family Physicians, and the Society of Adolescent Medicine.

The OSHCN will continue to promote access to a medical home for CSHNC through the PPEP. The plan for the PPEP is to access public and private insurance reimbursement for purposes of sustainability and to continue program evaluation. The OSHCN will continue to enhance medical homes for young adults through the Rhode Island Transition Clinic.

The OSHCN will continue to support the training and implementation of the CMS Innovations Challenge Grant with the Women & Infants Hospital Program for medically complex CSHCN in Rhode Island. Under the recently awarded CMS Innovations Challenge, these programs (including an OSHCN trained and supported parent consultant) will be expanding for medically complex infants with special health care needs in Rhode Island.

The OSHCN will continue to participate on the CEDARR Interdepartmental Team and in convening consumer input opportunities. Through these partnerships, the state will address care coordination for CYSHCN and additions to the Medicaid package. DCFHE is ensuring support of the medical home through RI's EPSDT Schedule.

The OSHCN will continue to collaborate with Family Voices Leadership Team to address the systems barriers to a coordinated service delivery system and support the preventative and screening functions of the medical home through RI's revised EPSDT Schedule.

HEALTH's Center for Health Data and Analysis (CHDA) will continue to gather data and determine the percent of RI's CSHCN with medical homes.

The OSHCN will continue to partner with the DCFHE's Chronic Disease Team on workforce capacity to support the medical home, including parent consultants, resource specialists, peer navigators, asthma educators, diabetes educators, Living Well Self-Management programs, cancer peer navigators, and cardiovascular disease educators.

DCFHE will continue to provide TA to Woonsocket and Washington County CATCH partners and identify 2 more communities to pilot the adolescent medical home model //2013//.

/2014/The DCFHE's Title V-funded CHEW project wil continue to include replication of the Harlem Children's Zone's Asthma Initiative in lower South Providence through FSRI //2014//.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	68.2	68.2	68.5	70.2	65
Annual Indicator	68.2	68.2	68.2	65	65
Numerator					
Denominator					
Data Source	CSHCN survey	CSHCN survey	CSHCN survey	CSHCN survey	CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	65	65	68.5	68	67.8

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and

the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
/2013/ Data from the 2009/2010 National Survey of CSHCN indicates that 65% of families with CSHCN have adequate private and/or public insurance to pay for the services they need. This percentage is a decrease from 2005/2006 NS-CSHCN results of 68.2% //2013//. ***/2014/ However, data is not comparible accross years //2014//.*** RI has a high rate of insured children as a result of the state's collective commitment to the RIte Care Program. This performance measure reminds RI that insurance status alone does not mean that families can pay for all the services they need.

The OSHCN worked collaboratively with the state's Medicaid office to enhance the EPSDT benefit and availability of services. The DCFHE continued to work to increase the percentage of CSHCN with adequate insurance to pay for the services they need.

/2013/ The PPEP assisted numerous families with CYSHCN on issues concerning insurance, education, and access to mental health services. Many of these families required direct assistance in accessing insurance.

First Connections continued to identify families with no or inadequate health insurance and refer them to appropriate programs and services, including Medicaid, SSI, and Katie Beckett.

The DCFHE supported the toll-free Family Health Information Line, which continued to refer families to appropriate resources, including Medicaid, SSI, and Katie Beckett. The Family Health Information Line is a statewide resource for all families, including those with CSHCN, and is staffed by bi-lingual information specialists. Culturally appropriate informational materials for families were distributed through HEALTH's centralized distribution center //2013//.

The OSHCN provided Complete Care Notebook to families to track expenses and determine adequacy of insurance. The DCFHE distributed and evaluated the use of condition-specific resource guides which detail financing options for families raising CYSHCN. The DCFHE worked to ensure accurate information concerning federal health care reform reaches community providers and consumers.

The OSHCN worked with community partners, advocacy organizations and local providers to increase access to care and address barriers to enrollment. Specifically, the OSHCN contracts with the RI Family Voices Program to provide outreach and education concerning financing health care for children with special health care needs and their families. The Family Voices conducts workshops, presentations and information and referrals to thousands of parents and professionals on an annual basis.

DCFHE staff continued to participate in the RIte Care Consumer Advisory Committee. This committee is convened monthly by /2013/ OHHS and is charged with ensuring that RIte Care families' needs are at the center of program decision-making.

DCFHE staff participated in several Health Care Reform Implementation Committees organized through the Lt. Governors' Office //2013//.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Worked with the Health Insurance Commissioner to ensure that private health insurers fund necessary services.				X
2. Supported the PPEP, First Connections, and MIECHV Program, which link families with CSHCN to Medcaid, SSI, and Katie Beckett.		X		
3. Worked with the state's Medicaid Office to enhance the EPSDT benefit and availability of services.				X
4. Supported a Family Resource Specialist position in the Katie Beckett unit of OHHS to help respond to families' concerns and questions.	X			
5. Supported the toll-free Family Health Information Line and RIPIN Resource Center to link families with CYCHCN to health insurance options.			X	
6. Distributed and evaluated the Complete Care Notebook and other CYSHCN resource guides.		X		
7. Participated in health care reform implementation committees organized through the Lt. Governors' Office.				X
8.				
9.				
10.				

b. Current Activities

HEALTH working with the Health Insurance Commissioner to ensure that the state's private insurance providers fund necessary services.

OSHCN is working collaboratively with the state's Medicaid office to enhance the EPSDT benefit and availability of services. OSHCN successfully worked with the Joint Commission for Educating Children with ASD to pass private insurance mandated coverage for the identification and treatment of children with an ASD.

/2013/ PPEP, First Connections, and MCHB funded MIECHV home visiting programs screen and refer eligible families for Medicaid, SSI and Katie Beckett.

OSHCN works with community partners, advocacy organizations and local providers to increase access to care and address barriers to enrollment. OSHCN supports a Family Resource Specialist position in the Katie Beckett unit within the EOHHS to assist the state in responding to families' concerns and questions //2013//.

The Family Health Information Line and the RIPIN Resource Center links callers to health insurance options.

/2103/ OSHCN continues to distribute and evaluate the use of condition-specific resource guides, including the Complete Care Notebook, which detail financing options for families raising CYSHCN. It also works to ensure accurate information concerning federal health care reform reaches community providers and consumers.

DCFHE staff continue to participate in several Health Care Reform Implementation Committees organized through the Lt. Governors' Office //2013//.

c. Plan for the Coming Year
The DCFHE will continue to work to increase the percentage of CSHCN, ages 0-18, whose families have adequate private and/or public insurance to pay for the services they need.

/2013/ The Department of Health will continue to work with the Office of the Health Insurance Commissioner to ensure the state's private insurance providers fund necessary services.

The OSHCN will continue to working collaboratively with the state's Medicaid office to enhance the EPSDT benefit and availability of services.

PPEP, First Connections, and MCHB funded MIECHV home visiting programs will continue to screen and refer eligible families for Medicaid, SSI and Katie Beckett.

The OSHCN will continue to work with community partners, advocacy organizations and local providers to increase access to care and address barriers to enrollment. The OSHCN will continue to support a Family Resource Specialist position in the Katie Beckett unit within the OHHS to assist the state in responding to families' concerns and questions.

The toll-free Family Health Information Line and the RIPIN Resource Center will continue to link callers to health insurance options.

The DCFHE will continue to distribute and evaluate the use of condition-specific resource guides, including the Complete Care Notebook, which detail financing options for families raising CYSHCN. The DCFHE will also continue to work to ensure accurate information concerning federal health care reform reaches community providers and consumers.

DCFHE staff will continue to participate in several Health Care Reform Implementation Committees organized through the Lt. Governors' Office. DCFHE will continue to ensure that equity remains a priority in state health care reform discussions //2013//.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	87.6	87.6	87.6	88	71.2
Annual Indicator	87.6	87.6	87.6	71.2	71.2
Numerator					
Denominator					
Data Source	CSHCN survey	CSHCN survey	CSHCN survey	CSHCN survey	CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	71.2	71.2	75.2	75.2	75.2

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

a. Last Year's Accomplishments
/2013/ According to the 2009/2010 National Survey of CSHCN, 71.2% of families of CSHCN can easily access community based services. RI's rate is higher than the national average of 65.1% //2013//.

Through consolidation of health and human service agencies, RI is addressing fragmented services and points of entry into social services, especially for CYSHCN and their families. /2013/ The OSHCN is committed to assisting families in navigating the special needs service delivery system as this was one of the goals of the PPEP, Family Voices contract, and the development of several resource guides //2013//.

DCFHE continued to build PPEP, which assists families of CYSHCN in accessing medical and community services. Services were expanded to several new sites. PPEP Resource Specialists were instrumental in training the central points of entry within the EOHHS.

DCFHE continued its participation in the implementation and ongoing quality assurance activities

for CEDARR, the state's care coordination system for CYSHCN and the implementation of the Global Medicaid Waiver. OSHCN staff contributed to program oversight and quality improvement through the CEDARR Interdepartmental Team.

OSHCN disseminated the Complete Care Notebook for Raising CYSHCN. The Notebook was developed in response to requests from families for a portable organizer to record and file their child's important health information. The Notebook also includes a community and state resource guide. The Notebook was distributed to families through the WIH NICU, Hasbro Children's Hospital Children's Neurodevelopment Center, and Early Intervention (EI) providers.

HEALTH took the lead in establishing a FLDI to develop a network of family leaders in RI to make a positive impact on schools, communities and in health care arenas. Through the FLDI, parents and caregivers throughout the system of care have access to systematic navigation of the state special needs programs of the DOH, /2013/ EOHHS //2013//, RIDE, DCYF and BHDDH. The FLDI provides consistent training and support needed to provide peer assistance and effectively advocate for person / family centered care at the individual, local, systems and policy level. Parent education and workshop sessions are provided through the RIPIN, Parent Support Network and Sherlock Center for Disabilities. Through this collaboration, 35 families participated in the Agents of Transformation Training that educated parent mentors in accessing the children's welfare and children's mental behavioral health system. There were 472 parents and professionals trained in navigating the special needs service delivery system such as basic rights, college success for students with disabilities, options for medical assistance, policy 101, transition planning, etc.

Parent support groups are organized throughout the state and HEALTH contracted with Family Voices to maintain a master calendar of support groups based on topic, age, and language. /2013/ Resource Specialists educate and empower families in the EI Program, PPEP, WIC, Birth Defects, Immunization, Community Asthma, Distribution Center, Emergency Preparedness, TBI, and Health Information Center. RI's 2012 Parent Professional Conference was dedicated to understanding the Changing System of Care for CYSHCN and Their Families and had over 250 participants //2013//.

/2013/ Successful Start worked to improve and coordinate the state's systems of early childhood services, with a special focus on systems serving CSHCN. Successful Start is an early childhood system building initiative with over 200 stakeholders, including leadership from state and community agencies. In 2003-2005 a strategic plan for early childhood system and services were developed, with the DCFHE facilitating the components of the plan since 2005. The five system components are medical homes, social and emotional health, early care and education, parent education, and family support. The Steering Committee worked to ensure that state agencies have consistent policies; funding streams are maximized and blended; gaps in services are identified; and families are able to access and receive needed services.

DCFHE and its Woonsocket CATCH partners developed a report and implemented strategies to improve adolescent medical homes, including establishing a satellite office of Thundermist Health Center at Woonsocket High School //2013//.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Worked with OHHS on integration initiatives including a modernization initiative that streamlines the application process for Medicaid/public welfare services and supports.			X	
2. Worked with OHHS and other state partners to address fragmentation of services and points of entry into social services				X

for CYSHCN.				
3. Supported the PPEP to support parent/peer consultants in pediatric primary/speciality care practices to collect data on systems barriers and help families access resources.		X		
4. Contributed to CEDARR oversight and quality improvement through participation in the CEDARR Interdepartmental Team.				X
5. Linked parents of CYSHCN with training and support needed to provide peer assisitance and advocate for person/family centered care.		X		
6. Provided families with resources to ease systems navigation including the Complete Care Notebook and other resource guides.		X		
7. Maintained a master calendar of support groups through RI Family Voices.			X	
8. Supported Resource Specialists to educate and empower families.		X		
9. Supported Sucessful Start to improve and coordinate the state's system of early childhood servcies, with a focus on sysyems serving CSHCN.				X
10.				

b. Current Activities

RI is addressing the ease of navigating services for families of CYSHCN through integration initiatives within DCFHE and OHHS including a Modernization Initiative that streamlines the application process for Medicaid / public welfare services and supports.

/2013/The OSHCN continues to work with EOHHS and other state partners to address fragmentation of services and points of entry into social services for CSHCN.

OSHCN continues to support PPEP. Parent / peer consultants (in 35 pediatric primary /specialty care practices) collect data on system barriers and assist families in accessing resources.

OSHCN continues to contribute to CEDARR oversight and quality improvement through participation in the CEDARR Interdepartmental Team.

The FLDI continues to link parents of CYSHCN with consistent training and support needed to provide peer assistance and effectively advocate for person / family centered care at the individual, local, systems and policy level.

OSHCN continues provide families with resources to ease in system navigation including the Complete Care Notebook.

Family Voices continues to maintain a master calendar of support groups.

Resource Specialists continue to educate and empower families in several programs.

Successful Start continues to work to improve and coordinate the state's systems of early childhood services.

/2013/ DCFHE continues to work with its Woonsocket and Washington County CATCH partners on adolescent medical homes //2013//.

c. Plan for the Coming Year

OSHCN will continue to work with EOHHS and other state partners to address fragmentation of services and points of entry into social services for CSHCN.

OSHCN will continue to support PPEP.

OSHCN will continue to contribute to CEDARR oversight and quality improvement through participation in the CEDARR Interdepartmental Team.

The FLDI will continue to link parents of CYSHCN with consistent training and support needed to provide peer assistance and effectively advocate for person / family centered care.

OSHCN will continue provide families with resources to ease in system navigation, including the Complete Care Notebook.

Family Voices will continue to maintain a master calendar of support groups.

Resource Specialists will continue to educate and empower families in several programs.

Successful Start will continue to work to improve and coordinate the state's systems of early childhood services, with a special focus on systems serving CSHCN.

/2013/ DCFHE will continue to work with Woonsocket and Washington County CATCH partners to provide TA and tools on adolescent medical homes and identify 2 more communities to pilot the adolescent medical home model //2013//.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	37.6	37.6	37.6	38.4	43.7
Annual Indicator	37.6	37.6	37.6	43.7	43.7
Numerator					
Denominator					
Data Source	CSHCN survey	CSHCN survey	CSHCN survey	CSHCN survey	CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	43.7	43.7	46.5	46.5	46.5

Notes - 2012

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

a. Last Year's Accomplishments

/2013/ According to the NS-CSHCN, youth with SHCN who received the services necessary to make appropriate transitions to adult health care, work and independence was 43.7% in 2009/2010. Although not comparable accross years, RI's percentage increased from 2005/2006 data and, for the first time, it has surpassed the national average. Increasing the successful transition from pediatric to adult healthcare has been identified by the DCFHE as a primary objective //2013//.

DCFHE developed a strategic plan to address all transitions from pediatric to adult health care by strengthening efforts on adolescent medical home. OSHCN, in collaboration with the RI-American Academy of Pediatrics (AAP), developed and administered a survey to all licensed practicing primary care pediatricians to further understand the health care transition process from the perspective of physicians. The findings of the survey were analyzed to develop outreach, training, and education strategies for youth, families, and health care professionals.

PPEP sites have been working on identifying youth with special health care needs (YSHCN) in need of transition support. OSHCN made presentations of the adolescent healthcare transition toolkit to physician, family, advocacy, legislative, and education groups. The OSHCN developed and disseminated a youth / parent self-assessment series entitled "Ready? Set... Go!" used to

encourage independence, personal responsibility, principles of self-determination, and adolescent development.

DCFHE worked with the adult and pediatric rehabilitation units at RI Hospital to facilitate a seamless transition to adult rehabilitative care. OSHCN partnered with the Adolescent Leadership Council, the MedPeds Clinic at RIH and the Hasbro Children's Hospital on a Transition Clinic that served 45 youth with complex special needs in need of specific transition medical consultation. The clinic provided youth with a transition plan, medical summary for youth / family and referring provider / group, preliminary contacts with adult care specialists, Emergency Health Record, and resources. DCFHE sponsored an interactive session at the 2010 Parent / Professional Partnership meeting with national and local transition specialists on transition issues.

/2013/OSHCN worked closely with EOHHS in the implementation and evaluation of the CEDARR Initiative and the transitioning of CSHCN from fee-for-service Medicaid to Medicaid managed care. In 2011, OSHCN provide TA to the EOHHS on enhancing CEDARR's role in the transition of youth with special health care needs from pediatric to adult services and supports //2013//. OSHCN ensured that YSHCN in Medicaid Managed Care were provided assistance in transitioning from pediatric to adult medicine.

DCFHE continued to participate on the RI Transition Council comprised of state departments, special educators, and familymembers that provides technical assistance to the state's regional transition centers and monitors the transition system. /2013/ OSHCN participated in the National Secondary Transition Technical Assistance Center's (NSTTAC) State Planning Session as a part of RI's State Team. The Team wrote transition goals concerning student leadership development and incorporating Dare to Dream initiative activities.

In May of 2009, OSHCN and the Council sponsored a statewide initiative and the first youth with disabilities or special health care needs leadership conference entitled Dare to Dream. The goal of the conference was to provide a forum for high school students with disabilities or special health care needs to begin to explore transition from school to adult life and develop self-determination and self-advocacy skills. Held on a college campus, the conference days' event included a plenary session where a selected adult motivational speaker with a disability shares their life experience as a motivation to encourage students to set goals for their own future. Dare to Dream has evolved to not only include an annual youth conference but also ongoing leadership development opportunities, youth development materials, and through the initiative proposed here, to a mentoring program //2013//.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Disseminated an adolescent healthcare toolkit to providers, families, and youth through PPEP and other venues.		X		
2. Disseminated the Youth Transition Workbook to help youth better understand their disability in relation to life goals.		X		
3. Supported the TALC and Transition Clinic at RI Hospital for youth with complex SHCN in need of medical transportation services.	X			
4. Worked with RIAAP and Hasbro Children's Hospital to define EPSDT requirements for transition planning.			X	
5. Supported the Dare to Dream Student Leadership Initiative, including a youth conference and leadership development.		X		
6. Employed and trained 10 youth with disabilities as Youth Head coaches.		X		

7.				
8.				
9.				
10.				

b. Current Activities
OSHCN continues to disseminate adolescent healthcare toolkit to providers, families and youth including the self-determination checklists, physician checklist, and youth leadership opportunities directory. PPEP sites are implementing the adolescent healthcare toolkit and the Physician Checklist.

OSHCN developed the RI Youth Transition Workbook to introduce the concepts of transition by using activities to help youth better understand their disability in relation to life goals and determine the steps to take in community membership.

OSHCN continues to support the TALC and Transition Clinic at RI Hospital for youth with complex SHCN in need of medical transition support.

OSHCN is working with the RI AAP and the Hasbro Children's Hospital on defining the EPSDT requirement for transition planning. To date, transition principles, transition products, and procedure codes have been identified.

OSHCN continues Dare to Dream including an annual youth conference and ongoing leadership development opportunities. ***/2014/ OSHCN sponsors the youth Advisory Committee with monthly youth input sessions throughout 2013.***

DCFHE OSHA is participating in the Construction Career Days activities in which thousands of teenagers from the local construction vocational programs gather for demonstrations and training. DCFHE OSHA is participating in the program in an effort to educate youth about their legal rights as young workers and the safety and health aspects of entering into the workforce //2014//.

c. Plan for the Coming Year
The DCFHE will continue to prioritize the transitioning from pediatric to adult health care, work, and independence.

OSHCN plans to partner with the Transition Council, PPEP, and TALC addressing and sponsoring activities concerning the health and wellness of young adults with disabilities and chronic conditions. The educational component of the health and wellness activities will explore responsibility, decision-making, healthy lifestyles, and reducing secondary conditions to be incorporated in the Directory of Youth Leadership Development Opportunities.

OSHCN will continue to make the adolescent healthcare toolkit available to youth, parents and physicians and provide technical assistance as indicated. OSHCN will continue to participate on the Rhodes To Independence, Youth In Transition Subcommittee, the RI Transition Council and the Adolescent Leadership Council. OSHCN plans to expand the scope and reach of the Dare to Dream Student Leadership Initiative by providing technical assistance to schools and community youth groups in developing a youth leadership organization / club. ***/2014/OSHCN will continue to grow the use of Youth Health Coaches and the Youth Advisory Committee //2014//.***

OSHCN will continue to work to include OSHA standards in worksites and collaborate with the RI DLT on rights for teen workers.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(ii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	84.5	80.9	84.9	68.5	82.5
Annual Indicator	79.5	70.0	75.3	79.5	79.5
Numerator	9834	8660	9059	9080	8877
Denominator	12370	12371	12031	11416	11166
Data Source	National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	82.5	85.7	85.7	85.7	85.7

Notes - 2012
2012 data an estimate. Data for 2012 is not yet available.

Notes - 2011
Data for 2011 reflects an increase in immunization rate from 2010.

Notes - 2010
2010 Data: HRSA recommended states to use the coverage rate for the 4:3:1:3:3 series for NPM #7 (for Rhode Island = 76.3%). However, Rhode Island decided to report the coverage rate of the 4:3:1:3:3:1 series to be consistent with previous years.

Denominator is estimated based on number of resident births that occurred two years prior [2008 births].

a. Last Year's Accomplishments

Data Discussion

/2013/ Historically, Rhode Island's coverage rates have been among the nation's highest. In 2010, the National Immunization Survey estimated coverage rates in RI were greater than 90% for most vaccines, surpassing Healthy People 2020 goals. However, recent data reveal a disturbing trend in the second year of life. For the sixth consecutive year, Rhode Island's fourth dose of DTaP coverage rate remained below 90% (this rate changed from 94.7% in 2004 to 82.3% in 2009 to 85.8% in 2010). Coverage rates for the combination 4:3:1:3:3:1:4 series (68.9%) were below the national average (70.2%) in 2010. This trend can be attributed to the level of timely completion of the fourth dose of DTaP vaccine in the second year of life //2013//.

a. Last Year's Accomplishments

DCFHE continued to provide all recommended vaccines to providers, free immunizations to uninsured children, and immunization education to providers and the public. DCFHE focused its improvement rates on populations new to the country and state through it's support of the St. Joseph's Free Immunization Clinic that serves mostly uninsured and immigrant children. DCFHE continued to offer injectable and intranasal influenza vaccine for children ages six months through 18 years and conducted a statewide school-based influenza vaccination program for students in grades K-12. RI's influenza vaccination coverage rates for the 2010-2011-flu season ranked highest in the U.S. at 75%, compared to 44% nationally.

DCFHE continued its assessment of immunization rates of children receiving care through home childcare providers. Evening trainings were held in the Fall to update childcare providers on immunization requirements and offered help in filling out the immunization survey, as well as informed and educated providers about vaccine --preventable diseases. DCFHE maintained its partnership with DCYF and offers incentive credit for all licensed providers that attend the trainings.

DCFHE utilized the Newborn Developmental Risk Assessment Screening to capture maternal Hepatitis B information and newborn Hepatitis B vaccination and treatment information, which is stored in KIDSNET. Infants born to Hepatitis B positive mothers were referred to the Perinatal Hepatitis B Program for case management, to ensure completion of the Hepatitis B vaccination series.

The Newborn Developmental Risk Assessment Screening Program and KIDSNET continued to capture and store maternal Hepatitis B information. KIDSNET released a guide for HL7 immunization transactions to submit electronic immunization data to KIDSNET in standard format. The HL7 data exchange was successfully tested with one community health center and one electronic medical record.

The WIC Program assessed the immunization status of children receiving WIC services based on DTaP at certification appointments. Referrals, by a nutritionist to the provider, are made for those clients who appear not up to date. The Child Care Support Network continued to provide immunization informational materials to families accessing center and home-based child care services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided all recommended vaccines for all children in RI,			X	

including influenza vaccine during influenza season, for all children ages 6 months through 18 years.				
2. Provided free immunizations to uninsured and newly immigrated children.	X			
3. Revised and distributed culturally and linguistically appropriate immunization materials to families, health care providers, child care providers, and schools.			X	
4. Updated the Immunization Program website to include specific sections for health care professionals, child care providers, school personnel, and culturally diverse families.			X	
5. Hosted a biennial conference for school nurse teacher to provide up-to-date information on a variety of health topics, including immunizations.		X		
6. Used KIDSNET to track children's immunization status.				X
7. Provided TA, consultation, and resource materials to child care providers to ensure that children in child care are up-to-date on their immunizations.			X	
8. Provided Tdap vaccine to birthing hospitals to vaccinate post-partum women prior to discharge.	X			
9. Continued to enroll new pediatric and other providers of services to children and families in KIDSNET.			X	
10.				

b. Current Activities

/2013/DCFHE provides all ACIP recommended vaccines to providers, free immunizations to uninsured children, and education materials to providers / public. Vaccine is delivered directly to provider offices.

KIDSNET tracks the immunization status of children who receive state supplied vaccine. Providers may generate reports on their patients' immunization status and exchange information with managed care organizations.

The Child Care Support Network offers health consultation to childcare centers/ family childcare homes. Nurses review child health records (including immunization status), provide staff training and preventative health/safety TA, distribute educational materials, and refer families to community services and resources. EI sites are being connected to KIDSNET//2013//. ***/2014/ First Connections, MIECHV programs, and WIC sites view KIDSNET to access children's immunization status and if a child is behind on immunizations, they link them to follow-up care //2014//.*** /2013/ KIDSNET captures newborn developmental risk screening and stores maternal Hepatitis B information.

The Chronic Care and Disease Management programs, in its quality improvement work through the RI Chronic Care Collaborative, has pneumonia and flu vaccine for children and adults as a quality measure and through media campaigns, targets people with chronic disease to obtain flu and pneumonia vaccine //2013//.

c. Plan for the Coming Year

DCFHE will continue to provide all recommended vaccines to providers, free immunizations to uninsured children, and immunization education to providers and to the public. DCFHE will continue to offer both injectable and intranasal influenza vaccine for children ages six months through 18 years.

DCFHE continues to provide technical assistance and training for all Vaccine for Children-

certified providers. DCFHE will distribute patient and provider educational and resource materials and host its biennial school nurse teacher conference and Provider Breakfast.
/2014/DCFHE plans to conduct annual rather than biennial provider site visits to better support providers with initiatives to increase coverage rates. The DCFHE has contracted with a Quality Improvement physician to provide on-site assistance to improve coverage rates//2014//.

DCFHE plans to visit childcare centers in every community across the state to assess child immunization rates.

KIDSNET will continue to track the immunization status of all children who receive state supplied vaccine. Messages about the importance of immunizations will be included in KIDSNET-generated cards mailed to families of newborns.

KIDSNET will continue to update the immunization algorithm and data quality reports so that all reports and displayed data reflect current guidelines. Reports regarding invalid doses will be moved to the web for easy accessibility to immunization providers.

KIDSNET will monitor the use of the immunization report that pediatric providers generate, and will continue to share the use of such reports in a monthly newsletter, at quarterly stakeholder meetings and as a performance measure. KIDSNET will continue to work with managed care plans to exchange immunization information for health plan performance (HEDIS) reporting and allow health plans direct access to the KIDSNET system.

The Newborn Developmental Risk Assessment and Screening Program and KIDSNET will continue to capture and store maternal and newborn Hepatitis B information. The Perinatal Hepatitis B Program will continue to provide follow-up and case management for all Hepatitis B positive women and their infants.

The Perinatal Hepatitis B Program will work with Vital Records to identify home births and assess the HBsAg status of the mother. Hepatitis B positive women who deliver at home will be referred to the Perinatal Hepatitis B Program for case management, to assure completion of the baby's Hepatitis B vaccination series.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	18.3	18	17.3	13.7	11.8
Annual Indicator	17.4	17.7	13.7	12.0	10.2
Numerator	364	366	284	249	210
Denominator	20885	20688	20688	20688	20688
Data Source	Vital Records Birth File	Vital Records Birth File	Vital Records Birth File	Vital Records Birth File	Vital Records Birth File
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year,					

and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	9.9	10.2	11.6	11.2	10.8

Notes - 2012
Provisional data for 2012 continues to shows a decline in birth rates for teens 15 to 17 from 12.0 per 1,000 in 2011 to 10.2 per 1,000 in 2012. Data reflects calendar year and 2010 Census data used for denominator.

Notes - 2011
Provisional data for 2011 shows a decline in birth rates for teens 15 to 17 from 13.7 per 1,000 in 2010 to 12.0 per 1,000 in 2011. Data reflects calendar year and 2010 Census data used for denominator

Notes - 2010
Data for 2010 shows a decline in birth rates for teens 15 to 17 from 17.7 per 1,000 in 2009 to 13.7 per 1,000 in 2010. Data reflects calendar year and 2010 Census data used for denominator

a. Last Year's Accomplishments
Data Discussion
Teen pregnancy is a statewide problem in RI. Although there is more disparity in the core cities, every community is affected by teen pregnancy. /2013/ In 2011, the rate of birth for teenagers aged 15 through 17 years in RI was 12.0 per 1,000 //2013//. Locally and nationally, Hispanic girls have the highest rates of teen pregnancy. RI teen birth rates are highest in New England and have dropped at the slowest rate in New England. Providence has the third highest rate of second births among 18-19 year olds in cities with less than 100,000 population. DCFHE's goal for adolescents is to ensure that all graduate from high school healthy and ready to be productive citizens. Reducing RI's teen pregnancy rate is an important outcome to achieve that goal. DCFCHE will utilize community activations strategies to enable local capacity development to support adolescent health.

a. Last Year's Accomplishments
The DCFHE is committed to reducing teen birth rates and other risk behaviors through a three-pronged approach: 1) access to health care services, within the context of an adolescent medical home including family planning, 2) youth development programming that prepares adults and institutions to meet the developmental needs of youth, and engages youth in building skills, attitudes, knowledge and experience that prepare them for the present and future, and 3) /2013/ school and community-based activation strategies to support adolescent health. Current efforts are also framed around Medicaid expansion, insurance reimbursement, and patient centered medical homes as part of health care reform //2013//.

DCFHE received USDHHS Personal Responsibility Education Program (PREP) funds to implement evidence-based teen pregnancy prevention curriculum. DCFHE selected Wyman Center's Teen Outreach Program, a youth development program with demonstrated results in preventing teen pregnancy and supporting positive academic and health behaviors. DCFHE designed two competitive processes to identify local implementation partners and one statewide professional development partner.

/2013/ The DCFHE hosted the unveiling of the RI Alliance for Teen Pregnancy Prevention statewide strategic plan.

DCFHE continued to provide technical assistance to Woonsocket and Washington County CATCH partners on the development of adolescent medical homes, pediatric behavioral health services, and prenatal care for hard-to-reach populations //2013//.

DCFHE supported Title X family planning agencies to provide reproductive health services to teens. /2013/ The Family Planning Program provided no cost pregnancy testing and preconception counseling to teens in Title X agencies; those with a negative pregnancy test were provided with family planning services; those with a positive test were referred to the Adolescent Self-Sufficiency Program //2013//. Teens with identified health risks (i.e. smoking, nutrition, mental health services, intimate partner violence, etc.) were referred to appropriate follow-up services.

/2014/DCFHE and March of Dimes, hosted a Preconception Health Summit to provide strategies to integrate preconception health into policy, programs, and practice and move forward the state's Preconception Health Strategic Plan. Attendees included RI leaders in human services, education, and multi-disciplinary health care professions//2014//.

/2013/The RI Task Force on Premature Births began first year implementation of revised recommendations to address the mission of improving the health of children in RI by reducing the rate of premature birth. The Task Force's workgroups address recommendations directed at meeting the state's standards to identify strategies to reduce teen pregnancy, support state policies and programs that ensure access to comprehensive primary and preventive health care services for women, expand the range of services in all settings where women receive health care to include improved identification of health risks, preconception counseling, health information, and referrals for health risks associated with preterm birth , and enhance comprehensive, relationship family support programs to improve outcomes for women and their children and prevent subsequent teen pregnancy //2013//.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supported Title X family planning services including pregnancy testing for teens.	X			
2. Supported a statewide preconception health plan.				X
3. Staffed and participated across multiple work groups of the Task force on Premature Births.			X	
4. Participated in the Alliance for Teen Pregnancy Prevention strategic plan efforts.			X	
5. Planned for thr implemention of the evidence-based Teen Outreach Program approach to teen pregnancy prevention in 7 communities.	X			
6. Participated in the conference for youth providers supporting the Sexual Health Needs of RI Adolescents.			X	
7. Supported the First Connections and MIECHV home visiting programs to refer teens in need of family planning services to such services.	X			
8. Supported the Incredible Years parenting groups in Providence and Pawtucket/Central Falls.		X		
9.				
10.				

b. Current Activities

Family planning servicee continue to be provided to teens. ***/2014/The state's Preconception Strategic Plan has formulated a Preconception Health collaborative consisting of a wide variety of community partners. The Collaborative will convene to address preconception health through implementation of health care practices and promotion, comprehensive health policies, and public health initiatives. Provider education and increased access to confidential care for adolescents are two strategy areas in the plan.***

DCFHE continues to participate across multiple work groups of the RI Task Force on Premature Births and the RI Alliance for Teen Pregnancy Prevention strategic plan efforts.

DCFHE is implementing contracts with nine local community partners to implement the evidence-based Teen Outreach Program in 7 RI communities. A statewide plan for PREP funding was approved to implement the Teen Outreach Program, an evidence-based approach to teen pregnancy prevention in communities.

DCFHE staff is participating in the second annual conference for youth providers titled "Got Ur Game On? Rhode Island 2013, which will focus on youth culture and communication //2014//.

/2013/DCFHE continues to provide TA to Washington County and Woonsocket CATCH partners.

DCFHE supports the First Connections and MIECHV home visiting programs to refer teen mothers in need of family planning and other support services //2013//.

/2014/The DCFHE's CHEW project includes Incredible Years parenting groups//2014//.

c. Plan for the Coming Year

/2013/ DCFHE will continue to provide teens with access to family planning services, pregnancy testing, and preconception counseling. DCFHE will begin implementation of the preconception health strategic plan to assure that youth and young adults seeking pregnancy tests receive referrals to risk prevention services and family planning as appropriate.

The Task Force on Premature Birth will continue to work on implementing its recommendations //2013//. ***/2014/ Specifically, the Task Force will address teen pregnancy reduction through collaborative efforts with the Rhode Island Alliance and recommend expanding the use of evidence-based teen pregnancy prevention models in schools and in the community.***

DCFHE will continue to provide training and technical assistance in the Teen Outreach Program to nine community partners to enable the implementation of this evidence-based program //2014//.

DFCHE will develop opportunities to work with communities on adolescent health issues, developing assets and reducing health risks. DFCHE will seek new opportunities to engage youth in action research in a variety of health risk areas.

DCFHE will continue to track births to teens and examine trends by demographic factors.

/2013/ DCFHE will continue to support the First Connections and MIECHV home visiting programs to, among other things, refer teen mothers in need of family planning and other support services.

DCFHE will continue to provide TA to its CATCH partners //2013//.

/2014/The DCFHE's CHEW project will continue to include Incredible Years parenting groups in Providence and Pawtucket Central Falls //2014//.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	36.3	36.9	39.5	41.1	42.1
Annual Indicator	38.6	38.6	40.1	39.1	39.1
Numerator	4625	4625	1335	4088	4088
Denominator	11987	11987	3332	10456	10456
Data Source	Oral Health Program	Oral Health Program	Oral Health Program	Oral Health Program	Oral Health Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	39.1	45	45	45	45

Notes - 2012
Data are estimated. The 3rd graders' oral health survey is conducted every three years. The next statewide survey will be conducted in 2013-2014 school year.

Notes - 2011
*39.1% is Weighted data: adjusted to reflect the probability of sampling and response rate in the survey.
During the 2010-11 school year, the Rhode Island Department of Health Oral Health Program conducted a statewide oral health screening survey of third graders. Screenings were completed at 79 randomly-selected elementary schools with 68 percent of enrolled third grade students in participating schools screened. In total, about a third of Rhode Island's third grade children (3,266 of 10,709 children) were screened. To read more details about the survey methodology and outcomes, please see "The Oral Health of Rhode Island's Children 2012" at: http://www.health.state.ri.us/publications/reports/2012OralHealthOfRhodeIslandChildren.pdf

Notes - 2010
During the 2010-2011 school year, the Rhode Island Department of Health Oral Health Program conducted a statewide oral health screening survey of third graders. Screenings of 3,332 students were completed at 81 randomly selected elementary schools. The reporting figures are not population estimates, which means the raw data are not yet adjusted to account for the survey sampling design and school/student participation rates.

a. Last Year's Accomplishments
Data Discussion
/2014/ Annual MCH Title V reports require annual data collection to measure RI's

performance. However, statewide data for this performance measure is collected every three years, with the next oral health basic screening of third graders scheduled for the 2013/2014 school year. Based on previous statewide data, the 2010-2011 RI third grade oral health basic screening survey //2014// //2013/revealled that 39.1% of third graders living in Rhode Island's core cities had dental sealants on at least one molar tooth //2013//. ***/2014/ These results indicate that RI has not met the annual performance objective and must continue to promote delivery systems and use of dental sealants as an important preventive measure among medical and dental practitioners //2014//.***

a. Last Year's Accomplishments

/2014/ Funded through Title V, the Seal RI program provided funding to school-based dental programs that services schools in low socio-economic, high risk communities (i.e. schools with > 50% of students eligible for the free/reduced school meal program) during the 2011/2012 school year. Of the 365 third grade children screened through the RI Seal Program, 78% either already had at least one dental sealant or received at least one dental sealant. These data demonstrate the success of RI Seal in proving access to preventive intervention and decreased oral disease rates. Additionally, The DCFHE continued to work with numerous state agencies and community partners to improve children's access to oral health services and prevent dental caries in children //2014//.

Parents of young children receiving home visiting services through the First Connections ***/2014/ and MIECHV home visiting programs //2014//*** continued to receive culturally and linguistically appropriate information and education about early childhood caries and the importance of preventive dental care.

/2013/ Families receiving WIC services were provided with information about early childhood caries. All local WIC staff were offered technical training on oral health topics. Education materials addressing oral health issues were developed by the WIC Program in conjunction with HEALTH's Oral Health Program and they are currently used during counseling during WIC certification appointments. Through this grant, HEALTH promotes "common sense" oral health practices for young children by teaching parents and Head Start providers about early childhood tooth decay prevention. The "common sense" practices include drinking fluoridated water, daily brushing with fluoridated toothpaste, proper use of bottles and sippy cups, healthy nutrition, and annual visits to a dentist, starting at age one.

The DCFHE continued to participate on and hold positions of leadership on the Rhode Island Oral Health Commission, a statewide coalition of public, private, and not-for-profit stakeholders working to improve the oral health of all Rhode Island residents, including school-age children, and CSHCN. Additionally HEALTH and the Commission are working to increase access to primary and preventive dental services for children and families covered by Medicaid and underserved Rhode Islanders.

The Center for Health Data and Analysis (CHDA) continued to survey mothers of two year-olds via the Toddler Wellness Overview Survey (TWOS), which includes questions related to oral health. In collaboration with CHDA, the Oral Health Program analyzed and published PRAMS data on oral health and pregnancy. The Oral Health Program coauthored a paper on early childhood preventive dental visits in Medicaid in collaboration with the RIDHS //2013//.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supported the First Connections and MIECHV home visiting programs and WIC to provide culturally competent information to	X			

families about early childhood caries/prevention.				
2. Supported the Child Care Support Network to proivde oral health consultation to child care centers conducing child health record reviews.				X
3. Supported school-based dental/sealant programs.	X			
4. Collaborated with school-based health centers to refer teens to oral health services.		X		
5. Supported the annual Oral Health Summit.			X	
6. Supported the implementation of the Oral Health Plan for RI.				X
7. Supported interdisciplinary oral health education specifically trageting pediatric health care providers and the Oral Health Commission's plans to implement an oral healthliteracy campaign targeting young children.			X	
8. Supported the Mission of Mercy initiative which provides free dental care to uninsured, low-income residents.	X			
9. Supported the collection and analysis of TWOS, PRAMS, BRFSS, and Medicaid oral health data.			X	
10.				

b. Current Activities

/2014/ Title V funds continue to support school-based dental sealant programs //2014//.

DCFHE and the Oral Health Commission, hosts annual state Oral Health Summits. In FY2011, the Oral Health Plan for 2010-2016 was released and widely disseminated to policy makers and stakeholders statewide.

DCFHE is working with partners on interdisciplinary oral health education, specifically targeting primary pediatric health care providers. DCFHE is partnering with the Commission on an oral health literacy campaign targeting early childhood caries awareness and prevention for high risk populations.

HEALTH participates in the inaugural Mission of Mercy initiative, which provided free dental care to uninsured, low-income Rhode Islanders.

/2014/ Parents of young children receiving WIC, First Connections, and MIECHV services receive culturally and linguistically appropriate information and education about early childhood caries and the importance of preventive dental care //2014//. The Child Care Support Network's Consultants offer health consultation to child care centers.

/2013/ TWOS, BFFSS, & PRAMS data continue to be collected and analyzed //2013//.

c. Plan for the Coming Year

/2013/ DCFHE will continue to work to prevent dental caries and increase children's access to oral health services by integrating education into DCFHE programs and by working with other internal and external partners to strengthen the state's dental services infrastructure //2013//.

/2014/Title V funds will continue to support school-based dental sealant programs //2014//.

/2013/Parents of young children who receive home visiting services through the First Connections and MIECHV home visiting programs will continue to receive culturally and linguistically appropriate information and education about early childhood caries and the importance of preventive dental care.

Families receiving WIC services will continue to be provided with culturally and linguistically

appropriate information about early childhood caries and the importance of preventive dental care and their first dental visit by age one.

The Child Care Support Network will continue to offer health consultation to child care centers and family child care homes throughout the state. Oral/dental health will be included in the range of physical and developmental health issues that the health consultants will address.

/2013/ The OHP will continue to monitor progress made on goals and objectives outlined in the Oral Health Plan. The OHP will continue to integrate oral health into all general health materials (intake forms, questionnaires, educational materials, etc.) utilized by CSHCN counselors through the Support to States for Oral Health Workforce Activities. OHP will continue collaboration with internal and external partners on interdisciplinary oral health education, oral health literacy, and access to oral health services across the lifespan.

CHDA will continue to conduct the TWOS survey and analyze responses to the oral health questions and the Oral Health Program will continue to analyze data sources, including, but not limited to, BRFSS, PRAMS, YRBS, Hospital Discharge data, and Medicaid //2013//.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	1.5	1.5	1	1	2.1
Annual Indicator					
Numerator					
Denominator	173303	170753	170753	170753	170753
Data Source	Vital Records Death File	Vital Records Death File	Vital Records Death File	Vital Records Death File	Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Provisional	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	1	1	1	1	1

Notes - 2012
Data for 2012 are provisional and reflect children aged 0 -14.
Denominator is from the 2010 Census.

Issue: Rhode Island has not been able to report on PM 10 due to the number of events. There are fewer than 5 events over the last year and the average of the last 3 years is also fewer than 5.

Notes - 2011
Provisional data for 2011 reflect children aged 00-14.
Denominator is from the 2010 Census.

Issue: Rhode Island has not been able to report on PM 10 due to the number of events. There are fewer than 5 events over the last year and the average of the last 3 years is also fewer than 5.

Notes - 2010
Data for 2010 reflect children aged 00 -14.
Denominator is from the 2010 Census.

Issue: Rhode Island has not been able to report on PM 10 due to the number of events. There are fewer than 5 events over the last year and the average of the last 3 years is also fewer than 5.

a. Last Year's Accomplishments
Data Discussion
/2013/ According to data from the RI Vital Records data base, there were no deaths of children ages 14 and younger from motor vehicle accidents in Rhode Island in 2009. This figure represents a decline from the 2007 figure of 3 deaths among this age group from motor vehicle accidents and continues to be lower than the national death rate. According to data from the CDC, National Centers for Injury Prevention & Control Web-Based Injury Statistics Query and Reporting System (WISQARS™), nationally, the death rate for children ages 14 and younger from motor vehicle accidents decreased from 3.71 per 100,000 in 2001 to 2.80 per 100,000 in 2007; while the Rhode Island death rate has decreased during this time period from 1.93 to 1.59 //2013//.

Last Year's Accomplishments

First Connections continued to provide families with young children culturally and linguistically appropriate information regarding the proper use of car seats, air bag safety, and the safest location in the car for children (i.e. the back seat). Low-income families receiving homes visits were referred to the RI Safe Kids Coalition, which provides free car seats to low-income families.

Healthy Child Care RI, through the Child Care Support Network, continued to provide informational materials to families with children in child care and child care providers on the proper use of car seats, air bag safety, and the safest location in the car for children. ***/2014/The Initiative for a Healthy Weight, through a grant from the RIDOT, continued to distribute bicycle helmets and materials on proper use to children ages 2 -- 18 and their families //2014//.***

Deaths to children caused by motor vehicle crashes where the driver was impaired due to alcohol and/or drug intoxication is a public health concern in RI as well as the rest of the country. /2013/ In RI 40% of all motor vehicle fatalities are alcohol related (FARS, 2009) //2013//. RI Governor Chafee signed a primary seat belt law on June 30, 2011. This law allows police officers to ticket a driver solely on the basis that the driver is not wearing a seatbelt and makes enforcement of the law that covers children up to 18 years of age more likely.

Recommendations made by the RI Task Force on Premature Births included encouraging development of additional substance abuse treatment programs where women are not separated

from their children and where parental relationships for women in treatment are preserved.

DCFHE staff continued to participate on the Child Death Review Team, a multidisciplinary team led by the State Medical Examiner that reviews childhood deaths to identify risk factors and trends, and to inform prevention efforts. In RI, all deaths under 18 years of age regardless of cause must be reported to the Medical Examiner. The team is committed to the systematic, multidisciplinary review of these deaths. Encourage community-based partners, legislators, and public policymakers to take action to prevent other deaths and improve the safety and wellbeing of all children. The ultimate goal of the team is to reduce the number of child deaths in the state.

DFCHE and CHDA participated with RIDE on the development of a new school based survey for students, teachers and parents.

/2013/DCFHE worked with the Injury Prevention Center at RI Hospital (the host agency of RI Safe Kids) to prevent accidental childhood injury. Free bike helmets are distributed to any child seen in the ER due to a bike, roller blade, skateboard, snow sport, or scooter injury. Children seen in Hasbro Children's Hospital and the Children's Neurological Center are screened by nurses regarding helmet use. Children who do not have a helmet are provided with one. RI Hospital's Kohl's Cares for Kids Car/Booster Seat Program provides education on car/booster seat safety and car/booster seat inspections. Families may receive a car/booster seat free of charge. Reducing Youthful Dangerous Driving is an educational program provided to court-referred youth ages 16-20 years old. Youth are required to complete workshops and volunteer at RI Hospital or in the community. The Safe Playground and Sportsfield Project provides resources to make these sites safe. The Safety Store initiative provides families with CYSHCN with injury prevention education and appropriate safety equipment //2013//.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supported First Connections and MIECHV home visiting programs to provide pregnant women and families with young children with information about car safety and make referrals to the RI Safe Kids Coalition as needed.	X			
2. Supported First Connections and MIECHV home visiting programs to assess pregnant women and families with young children for alcohol and drug abuse and to make referrals for evaluation and treatment as needed.	X			
3. Supported the Child Care Support Network child care health consultants to provide informational materials about care safety to child care providers and families with children in child care.		X		
4. Supported the Family Planning Program to refer women with risks related to alcohol and drug abuse for evaluation and treatment.	X			
5. Supported the Preconception Health Strategic Plan, which includes alcohol and drug abuse a key health indicators to be routinely screened as part of preconception care.				X
6. Supported the work of the Task Force on Premature Births to develop a collaborative strategy with DCYF to identify pregnant women who misuse substances and maintain intact families.				X
7. Tracked children's deaths caused by motor vehicles and examined trends by demographic factors.			X	
8. Participated on the Child Death Review Team led by the State Medical Examiner.			X	

9. Worked with Injury Prevention Center at RI Hospital (the host agency of RI Safe Kids) to prevent accidental childhood injury.			X	
10.				

b. Current Activities

/2013/ First Connections and MIECHV provide families with information regarding car safety //2013//. Referrals are made to the RI Safe Kids Coalition. They also assess families for substance abuse. Women identified to be at risk for substance abuse are referred to assessment and treatment.

The Child Care Support Network provides information regarding overall injury prevention to child care providers and families. Health consultants in child care centers provide information and TA on a variety of child health and safety topics, including car safety.

/2014/Initiative for a Healthy Weight continues to distribute bicycle helmets and materials on proper use to children ages 2 -- 18 and their families //2014//.

/2013/Family Planning continues to refer women with risks related to substance abuse for appropriate evaluation and/or treatment services. The preconception health strategic plan includes substance abuse screening as a key health indicator.

The Task Force on Premature Births is developing a collaborative strategy with DCYF to develop effective and appropriate screening policies and procedures in order to identify pregnant women who misuse substances //2013//.

DFCHE will continue to track children's deaths caused by motor vehicles and to participate on the Child Death Review Team.

/2013/DCFHE continues to work with the Injury Prevention Center to prevent accidental childhood injury //2013//.

c. Plan for the Coming Year

First Connections and /2013/ MIECHV home visiting programs //2013// will continue to provide families with young children culturally and linguistically appropriate information regarding the proper use of car seats, air bag safety, and the safest location in the car for children (i.e. the back seat). /2013/ They will also continue to assess pregnant women and mothers with young children for alcohol and drug abuse. Women identified to be at risk for alcohol or drug abuse will continue to be referred to assessment and treatment programs as appropriate //2013//.

The Child Care Support Network will continue to provide informational materials regarding the proper use of car seats, air bag safety, and the safest location in the car for children to families with children in child care and to child care providers.

/2014/The Initiative for a Healthy Weight, through a grant from the Department of Transportation, will continue to distribute bicycle helmets and materials on proper use to children ages 2 -- 18 and their families. It has entered into a partnership with the YMCA of Greater Providence to include distribution of helmets and safety materials at the YMCA's mobile events with Y on the Move //2014//.

/2013/ The Family Planning Program is working with the Prematurity Task Force to identify a set of core health risks associated with preterm birth for integration in routine screening and to develop a referral resource of proven intervention strategies. The Family Planning Program will continue to provide free pregnancy testing and preconception counseling to women receiving pregnancy testing services in Title X family planning sites. As a part of preconception counseling,

women are assessed for risks related to substance abuse and referred for appropriate substance abuse evaluation and/or treatment services.

The Task Force on Premature Births work group will continue to work with the DCYF to develop effective and appropriate screening policies and procedures in order to identify pregnant women who misuse substances with the goal of decreasing prematurity and maintaining intact families //2013//.

DCFHE personnel will continue to participate on the Child Death Review Team led by the State Medical Examiner, which reviews child deaths to determine whether they were preventable.

/2013/ The DCFHE will continue to work with the Injury Prevention Center to prevent accidental childhood injury //2013//.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	32.5	42.5	42.5	44.7	40.5
Annual Indicator	40.4	40.4	45.1	38.0	46.8
Numerator	4997	4997	5579	4572	5345
Denominator	12370	12370	12371	12031	11421
Data Source	National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**

Annual Performance Objective	46.9	47.2	47.2	47.2	48.5

Notes - 2012
Data Source: CDC National Immunization Survey [NIS] , 'Breastfeeding Report Card 2012, Outcome Indicators'.
Per CDC, breastfeeding rates have been on the rise. Contributing factor to the increase is the improvement in hospital practices and the higher percent of infants born in Baby-Friendly hosptials.

Denominator for 2012 is Rhode Island resident births for 2009.

Notes - 2011
Data Source: CDC National Immunization Survey [NIS] , 'Breastfeeding Report Card, Outcome Indicators'.
Reporting method changed in 2011. Data prior to 2009, reflect children surveyed each year that were born 2 years prior to the survey. From 2009, data reflect children surveyed each year that were born about 3 years prior to survey.

Although data are provisional, there appears to be a significant decrease between 2010 and 2011 for breastfeeding at 6 months.

Denominator for 2011 is Rhode Island resident births for 2008.

Notes - 2010
Data Source: CDC National Immunization Survey [NIS] , 'Breastfeeding Report Card, Outcome Indicators'.

There is an increase between 2010 and 2009 for breastfeeding at 6 months.

Children surveyed each year are born about 3 years prior to survey. Therefore, denominator reflects Rhode Island resident births for 2007.

a. Last Year's Accomplishments
Data Discussion
/2013/ Rhode Island continues to prioritize supporting breastfeeding. Rhode Island is working with birthing hospitals to increase the number that are baby friendly since research shows that increasing the number of women who initiate breastfeeding will impact the number of those continuing to breastfeed at 6 months of age. RI has made working with employers to support breastfeeding a priority, recognizing employers who provide a place for women to breastfeed as well as distributing hospital grade electric breast pumps to WIC clients who are fully breastfeeding and are returning to work //2013//.

a. Last Year's Accomplishments

/2013/ The DCFHE continued to work to increase the percentage of mothers who breastfeed their infants at birth and at six months of age.

The WIC Program continued to support a lactation support program for WIC participants six days a week in a birthing hospital. Mothers who receive adequate lactation support after giving birth are more likely to continue breastfeeding after they leave the hospital. WIC also continued to support a "mother-to-mother" peer counselor program to provide culturally competent breastfeeding support to WIC participants at 10 of the 10 WIC agencies //2013//. ***/2014/ Peer counselor trainings were held yearly over the past two years //2014//.***

/2013/ The DCFHE maintained partnerships with the RI Breastfeeding Coalition (RIBC) and the Physicians' Committee for Breastfeeding in RI (PCBRI) and collaborated with these groups to update and carry out the initiatives of the statewide breastfeeding promotion plan. The DCFHE actively promoted adoption of the Baby-Friendly Hospital Initiative, a global program developed to encourage and recognize hospitals that offer an optimal level of care for lactation. The WIC program continued an electronic breast pump program to provide pumps to fully breastfeeding women who are returning to work or school, while expanding this program to women who are breastfeeding medically needy children and may be separated from the babies (i.e. Special care nursery), when insurance will not pay. The DCFHE Initiative for a Healthy Weight (IHW) direction is outlined in its Eat Smart Move More Plan for Action 2010-2015, which includes objectives to promote DHHS's Business Case for Breastfeeding and recognizes worksites that effectively accommodate breastfeeding mothers. IHW continued to provide funds to the RI Breastfeeding Coalition to increase worksites that support breastfeeding mothers.

During World Breastfeeding Week the DCFHE engaged state officials and the local media to recognize employers as Breastfeeding-Friendly Workplace Award in partnership with PCBRI. The WIC Program provided local WIC agencies with special funds to purchase sustainable breastfeeding promotion materials and to sponsor breastfeeding promotion events at their clinics.

The DCFHE continued to support the toll-free Family Health Information Line using Title V funds. Bilingual staff took calls from breastfeeding women and referred them to appropriate community resources. The DCFHE continued to distribute culturally and linguistically appropriate materials to health care providers and low-income families through hospitals, agencies, and private practices to facilitate the provision of accurate and consistent breastfeeding messages. WIC breastfeeding brochures were distributed within and beyond WIC sites. The DCFHE continues to update the breastfeeding resource website for parents, employers and health care providers.

KIDSNET continued to track the percent of mothers that breastfeed through First Connections Program and newborn developmental screening data. The DCFHE conducted both RI PRAMS and TWOS surveys which asks respondents about breastfeeding practices. PRAMS asks the mother whether she ever breastfed, whether she is still breastfeeding, and about barriers to breastfeeding. TWOS asks if the respondent ever breastfed and the duration she breastfed.

PRAMS survey data was collected and analyzed //2013//.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supported WIC lactation support services, WIC mother-to-mother peer counseling,l actation counselor training, and a breast pump loan program.		X		
2. Supported the RI Breastfeeding Coalition's efforts to help worksites support breastfeeding mothers.		X		
3. Supported First Connections/MIECHV home visiting programs to educate pregnant women about the importance of breastfeeding and to link new mothers with certified lactation couselors and other breastfeeding resources and support.		X		
4. Supported the Family Health Information Line to refer breastfeeding mothers and health care providers who serve breastfeeding mothers to breastfeeding resources and support.			X	
5. Supported CHDA to collect and analyze PRAMS and TWOS surveys, which ask respondents about breastfeeding practices.			X	
6. Distributed consumer breastfeeding informing material to		X		

health care providers and families.				
7. Maintained and updated a breastfeeding website.			X	
8. Supported KIDSNET and MIECHV to track the percentage of mothers who breastfeed through First Connections/MIECHV programs.			X	
9. Supported the CCN health consultants to provide child care providers with information promoting breastfeeding and help in how to support mothers who want to breastfeed.		X		
10.				

b. Current Activities

/2014/ WIC lactation support services are available in the state's largest and second largest birthing hospitals//2014//.WIC supports a "mother-to-mother" peer counselor program, Certified Lactation Counselor training for WIC peer counselors and nutritionists, a peer counselor program, and a statewide breast pump loan program which has been expanded to provide pumps to mothers who are separated from their infants because of a medical condition. ***/2014/ WIC collaborates with parent consultants to share resources across programs //2014//.***

IHW continues to support the RIBC to implement a Breastfeeding Friendly Workplace Award. DCFHE is promoting the Baby-Friendly Hospital Initiative and is collaborating with health insurers on breastfeeding benefits. DCFHE partners with the PCBRI on Breastfeeding Friendly Workplaces and the RIBC on work Breastfeeding Week.

/2014/First Connections and MIECHV provide information to families on the importance of breastfeeding and link new mothers with Certified Lactation Counselors //2014//.

The Health Information Line refers breastfeeding women/health care providers to resources. There is a Breastfeeding Resource Directory, Breastfeeding Pocket Guide for Providers, and breastfeeding website.

KIDSNET continues to track the percent of mothers that breastfeed. CHDA collects and analyzes both RI PRAMS and TWOS surveys which asks respondents about breastfeeding practices.

c. Plan for the Coming Year

/2014/ The federal Affordable Care Act requires coverage of breastfeeding support and equipment to make going back to work easier for breastfeeding mothers //2014//.

/2013/ DCFHE will continue to work to increase the percentage of mothers who breastfeed their infants at birth and at six months of age. First Connections and MIECHV will continue to make referrals to Certified Lactation Counselors. WIC will continue to support visits by lactation consultants to WIC participants in two of the state's birthing hospitals. WIC will continue to support a "mother-to-mother" peer counselor program to provide culturally competent breastfeeding support at WIC sites. Peer counselor trainings and Certified Lactation Counselor Certificate training will continue to ensure skilled and consistent breastfeeding services.

/2014/ WIC and MIECHV will work more closely together to link pregnant women who intend to breastfeed to WIC or MIECHV to provide comprehensive support prior to delivery and after birth //2014//.

WIC will continue to co-sponsor educational talks and events for health care providers and will continue to provide a statewide electric breast pump loan program.

IHW will continue to partner with the RIBC on helping work sites assist breastfeeding mothers through support of the Business Case for Breastfeeding toolkit promotion, breastfeeding-friendly workplace awards, partnerships with RI workplaces, and promoting the mini-grants to eligible work places.

DCFHE will continue to support World Breastfeeding Month activities and media promotion to

encourage women to breastfeed their infants. ***/2014/ The MIECHV and WIC programs will support grand rounds for all health care professionals including mid-wives, family physicians, nurse practitioners, and pediatricians //2014//.*** /2013/ The WIC Program will also continue to provide WIC agencies with special funds to purchase breastfeeding promotion materials and to sponsor World Breastfeeding Month events.

DCFHE will continue to support the toll-free Health Information Line to refer breastfeeding women and providers to appropriate community resources, and to distribute culturally and linguistically appropriate breastfeeding materials to health care providers and low-income families through hospitals, agencies, and private practices and will continue to update the breastfeeding website.

KIDSNET will continue to track the percentage of mothers who breastfeed through First Connections, //2013// ***/2014/ MIECHV //2014//***, /2013/ and newborn developmental screening data.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(ii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	97.3	98.9	99.4	99.4	99.6
Annual Indicator	97.8	94.0	98.8	99.0	98.6
Numerator	12073	11086	11507	11463	11314
Denominator	12343	11798	11647	11580	11480
Data Source	Universal NewBorn Screening	Universal NewBorn Screening	Universal NewBorn Screening	Universal NewBorn Screening	Universal NewBorn Screening
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	99.6	99.6	99.6	99.6	98.6

Notes - 2012
2012: Data was provided by the Universal New Born Screening Program and reflects total screened before DISCHARGE.
Denominator reflects births occurring in Rhode Island minus 156 screenings with invalid or unknown screening dates.

Notes - 2011
2011: Data was provided by the Universal New Born Screening Program and reflects total screened before DISCHARGE. Prior to 2008, data reflected total screened by one month old. Denominator reflects births occurring in Rhode Island minus 149 screenings with invalid or unknown screening dates.

Notes - 2010
2010: Data was provided by the Universal New Born Screening Program and reflects total screened before DISCHARGE. Prior to 2008, data reflected total screened by one month old. Denominator reflects births occurring in Rhode Island minus 196 screenings with invalid or unknown screening dates.

a. Last Year's Accomplishments
Data Discussion:
/2013/ Annual data shows that Rhode Island continues to maintain high rates of newborn hearing screening. Ninety-nine percent (99%) of all babies born in Rhode Island receive a hearing screen. Babies with positive or inconclusive results are referred for a re-screen. The state has put quality assurance systems in place to ensure that these high rates of screening are maintained. It is tabulated for the national performance measure "screened by one month of age". In 2010, there were 11,843 births. 11,507 (97%) babies were screened prior to discharge, 67 died, and 269 were not screened by hospital discharge for other reasons. Of the 111,723 screened, 11,555 (98.6% of all births) were screened by one month of age. There are systems in place to track and assure that every baby is screened and the screening rates are very high. Very few infants are ever discharged without a screen and there is a system in place to identify home births in need of screening. In 2010, only 50 infants were lost to follow up //2013//.

a. Last Year's Accomplishments
The RI Hearing Assessment Program (RIHAP) ensures that all newborns receive hearing screening prior to hospital discharge. The DCFHE utilizes KIDSNET to track RIHAP screening information, which originates through the newborn screening process. Infants with confirmed hearing impairment are referred to Early Intervention. First Connections Program home visitors also continue to track infants who are lost to follow-up by RIHAP. The newborn hearing screening database is pre-populated with birth information collected on an integrated newborn developmental risk assessment and birth certificate system then sent to KIDSNET. Two way data exchange between KIDSNET and RITrack allows RIHAP to match birth data to assure that all infants have a hearing screen with a result in KIDSNET. RIHAP and KIDSNET follow up when a child was missed or if the data was never entered into KIDSNET. Rhode Island-specific Newborn Hearing Screening process algorithms adopted from the American Academy of Pediatrics Early Hearing Detection and Intervention (EHDI) guidelines were mailed to primary care providers caring for infants. A system was put into place to mail the algorithm to providers when a newborn in their practice requires follow-up related to the newborn hearing screen.

Informing brochures continued to be distributed in English and Spanish at three time points (prenatal, perinatal, postnatal). The brochures include information on several programs including bloodspot, hearing, developmental risk, home visiting, birth defects surveillance, and KIDSNET. RI PRAMS continues to collect data on parental awareness that babies are tested in the hospital for hearing loss.

The Birth Defects Program and KIDSNET continues to work with the Newborn Screening Program to ensure that a final diagnosis of hearing loss in an infant is recorded and reported to the Birth Defects Program.

/2013/ The newborn hearing screening quality assurance committee continued to meet. Representatives from the Newborn Screening Program, RIHAP, and the Early Intervention Program meet as needed to assure that every baby referred has had audiological evaluation and

that every baby diagnosed with a hearing loss is enrolled in Early Intervention (or the parents have chosen not to participate). A parent consultant at RIHAP follows up with families who did not receive screening and or diagnostics before hospital discharge //2013//.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Ensured universal newborn hearing screening prior to hospital discharge.			X	
2. Ensured that infants identified with hearing impairment are referred to the RI School for the Deaf and Early Intervention.		X		
3. Supported First Connections to track infants lost to follow-up by the RI Hearing Assessment Program.		X		
4. Utilized KIDSNET to track hearing screening information and refer newborns who do not have a hearing screening to the RI Hearing Assessment Program for follow-up.				X
5. Worked to ensure that a final diagnosis of hearing impirment is recorded and reported to the the Birth Defects Program.			X	
6. Collected and analayzed information on family awareness about newborn screening through PRAMS.			X	
7. Distributed integrated culturally and linguistically appropropriate brochures that include hearing screening.		X		
8. Continued efforts to connect all pediatric audiologits in KIDSNET.				X
9.				
10.				

b. Current Activities

All newborns receive hearing screening prior to hospital discharge. Infants identified with hearing loss are referred for services. First Connections tracks infants lost to follow-up.

KIDSNET continues to send RIHAP electronic birth records to assure all newborns were screened. RIHAP provides hearing results to parents prior to discharge along with the newborn screening brochure. If follow up is necessary an appointment is scheduled prior to discharge. Audiologists are connected to KIDSNET. /2013/ Training audiologists to report on-line through KIDS NET is ongoing //2013//.

DCFHE continues to distribute integrated newborn screening brochures to families when the hearing screening is completed along with a system for distribution of similar brochures at the prenatal and postnatal time points.

/2013/ A system to cross check birth records with vital records to identify home births is in place //2013//. DCFHE received HRSA funding to reduce loss to follow up by coordinating with home visiting services to provide screenings in the home.

2013/A pilot test and validation of sending results electronically directly from screening equipment to RITRACK is in process //2013//.

c. Plan for the Coming Year

Data systems in KIDSET will support new activities implemented with new HRSA funding. 2013/ Electronic submission of results from hearing screening equipment to RITRACK will be rolled out

to all home births and hospitals following the pilot project and validation process. RIHAP will continue to assure that all newborns receive hearing screening prior to hospital discharge. The DCFHE will utilize KIDSNET to track RIHAP screening information, which originates through the newborn screening process. Infants who are identified with hearing loss will continue to be referred to Early Intervention. A parent consultant will continue to follow up on all children who need it. First Connections Program home visitors will also continue to track infants who are lost to follow-up by RIHAP, and will work with RIHAP to begin to implement new in-home screening in conjunction with home visiting activities. Specifications for an on-line referral and tracking system for in-home screening in KIDSNET will be developed //2013//. ***/2014/ Staff from DCFHE and RIHAP will participate in a learning collaborative and will also begin to work with Early Head Start and other home visiting providers to support them as they conduct hearing screening //2014//.***

/2013/ KIDSNET will continue efforts to train all pediatric audiologists to access newborn hearing screening results and Early Intervention information and to use on-line diagnostic reporting into KIDSNET //2013//.

The DCFHE will continue to distribute integrated newborn screening brochures to families at the prenatal, hospital, and postnatal time periods. This brochure discusses the importance of following up on recommendations received following newborn hearing screening and is available in English and Spanish. A family version of the newborn hearing-screening algorithm will be distributed in English and Spanish to families of infants requiring follow-up after the newborn hearing screen. Upgrades to the HEALTH and RIHAP websites will be completed. The DCFHE will continue to distribute the Resource Guide for Families of Children who are Deaf or Hard of Hearing to assist families in navigating and accessing services.

The Birth Defects Program will continue to work with the Newborn Screening Program and KIDSNET to ensure that a final diagnosis of hearing loss in an infant is recorded and reported. In addition, RI PRAMS will continue to survey recent mothers regarding parental knowledge that babies are tested in the hospital for hearing loss. PRAMS will provide data to evaluate if introduction of the brochures or family algorithm is related to an increase in awareness, particularly among subpopulations such as Spanish-speakers.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(ii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	5.7	8.8	7.3	5.9	6.5
Annual Indicator	7.9	6.6	5.4	5.8	6.2
Numerator	18644	15000	12100	13250	14109
Denominator	236000	226000	224000	227000	227000
Data Source	CPS - Table HIA-5	CPS - Table HIB-5	CPS - Table HIB-5	EstimatedCPS - Table HIB-5	Estimated
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of					

events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	5.8	6.2	6.2	6.5	5.8

Notes - 2012
Data are estimated.

Notes - 2011
2011 Data is from US Census Bureau March Current Population Survey [CPS]:
Table HIB-5: Health Insurance Coverage Status and Type of Coverage by State - Children under 18. Data are updated to reflect the most recent tables provided. Both numerator and denominator are from Table HIB-5.

Notes - 2010
2010 Data is from US Census Bureau March Current Population Survey [CPS]:
Table HIB-5: Health Insurance Coverage Status and Type of Coverage by State - Children under 18. Data are updated to reflect the most recent tables provided. Both numerator and denominator are from Table HIB-5.

a. Last Year's Accomplishments
Data Discussion
/2013/ Between 2008 and 2010, 6.3% of Rhode Island's children under age 18 were uninsured, compared with 9.7% of children in the United States. Rhode Island ranks 13th best in the nation, with 93.7% of children with health insurance. About 73% of the estimated 17,053 uninsured children in Rhode Island were eligible for Rite Care coverage based on their family incomes, but were not enrolled. The National Health Care Reform Law will provide Rhode Island with new opportunities to expand access to health care coverage for children //2013//.

a. Last Year's Accomplishments
/2013/ Family Health Information Line Information Specialists continued to refer callers without health insurance to RIte Care.

The PPEP assisted families with CYSHCN on issues concerning health insurance, education services, and access to mental health services. Through this program, trained parent consultants are placed in pediatric and specialty care practices to assist families with CYSHCN in accessing community resources, to assist physicians and families in accessing specialty services, and to identify barriers to coordinated care //2013//.

/2014/The First Connections and MIECHV programs referred uninsured and underinsured families with newborns and young children to RIte Care, SSI, and Katie Beckett, and other health care options, including community health center services and hospital charity care, as appropriate. In addition, First Connections and MIECHC programs ensured linkages to many other community based resources including, but not limited to, WIC and Early Intervention.

First Connections and MIECHV home visitors provided information to all families receiving a home visit about new Medicaid recertification requirements. First Connections home visitors worked with the Department of Human Services to streamline the recertification process //2014//.

/2013/DCFHE provided TA to Woonsocket and Washington County CATCH partners to build the capacity of medical homes and link children to needed health and human services. DCFHE was also a key partner in Covering Kids RI, a coalition of partners working statewide and locally to ensure that all children and adults eligible for RIte Care were enrolled and retained their coverage.

The Child Care Support Network also referred uninsured or underinsured families with young children to RIte Care, SSI, and Katie Beckett, and other health insurance options, SSI, and Katie Beckett, and other health insurance programs, as appropriate. Child care health consultants worked with licensed child care providers to ensure that all of the children in their care have access to health insurance and facilitate the enrollment of those who are eligible but not enrolled.

The Title X Family Planning Program continued to provide affordable family planning services to adolescents in need of confidential services. The Task Force on Premature Births continued to advocate for an income-based family planning State Plan Amendment to enable low-income women, men and adolescents who wouldn't otherwise be eligible for Medicaid to obtain family planning services.

PRAMS continued to survey women two to four months after delivery and asked about their baby's health insurance status. The TWOS survey also included questions regarding health insurance. Data from the National Survey of Children's Health were also analyzed to determine insurance coverage among children in Rhode Island.

One recommendation made by the Rhode Island Task Force on Premature Birth included supporting state policies and programs that ensure access to comprehensive primary and preventive health care services for women and children, specifically that RIte Care eligibility standards for children, parents, and pregnant women and RIte Care's comprehensive benefits package be preserved.

The Office of Primary Care and Rural Health conducted a survey of Primary Care Physicians statewide, to identify areas of underservice and gather information on access to care for uninsured and underinsured populations, particularly low-income and minority populations. The Office managed legislative grants made to RI Community Health Centers to defray uncompensated care costs due to increases in uninsured populations //2013//.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supported the toll-free Family Health Information Line which refers families without health insurance to RIte Care and other community resources.		X		
2. Supported the PPEP to assist families with CYSHCN on issues concerning health insurance, education services, and mental health services.		X		
3. Supported First Connections and MIECHV home visiting programs to refer pregnant women and families with young children to Rite Care and other health care services for which they may be eligible.	X			
4. Supported the Child care Support Network to assure that child care providers refer uninsured and undersinsured families with young children to RIte Care and other health care services for which they may be eligible		X		
5. Supported Minority Health Promotion Centers to refer uninsured and underinsured families to RIte Care and other	X			

health care services.				
6. Supported the Title X Family Planning Program to provide confidential family panning services to teens.	X			
7. Supported the Task Force on Premature Births to advocate for expansion of coverage made possible through national health care reform.				X
8. Supported the Rural Health Systems Building Grants and HPSA/DPSA designation activities.			X	
9. Served on the Full Service Community School Alliance Board to connect families with school age children to services, including health care coverage.				X
10. Worked with key stakeholders and community partners to implement recommendations included in the Adolescent Access to Care Report.				X

b. Current Activities
/2013/ The Family Health Information Line refers callers without health insurance to RIte Care.

PPEP assists families with CYSHCN on issues concerning health insurance, education services, and access to mental health services.

First Connections and MIECHV refer families to RIte Care.

Child Care Support Network refers uninsured or underinsured families with young children to RIte Care.

DCFHE continues to work with its Woonsocket and Washington County CATCH partners on medical homes.

Title X provides affordable family planning services to teens in need of confidential services.

PRAMS & TWOS survey women about health insurance status. Data from the National Survey of Children's Health are also analyzed to determine insurance coverage among children.

OPCRH provides grants to increase outreach to rural uninsured and Medicaid-eligible populations. OPCRH analyzes primary care physician shortages and submits updates to maintain federal HPSA designations and eligibility for federal support through the CHC and NHSC programs.

DCFHE staff serves on the Full Service Community School Alliance Board. Full service schools provide a wide array of services for children and families including connecting families to health insurance.

The DCFHE's Refugee Health Program is working to increase the increase the percentage of refugees for whom a health screening form is submitted within 30 days of the refugee's arrival.

DCFHE produced an Adolescent Access to Care Report //2013//.

c. Plan for the Coming Year
/2013/ The Family Health Information Line will continue to refer callers without health insurance to RIte Care.

The PPEP will continue to assist families with CYSHCN on issues concerning health insurance, education services, and access to mental health services.

First Connections, MIECHV, and the Child Care Support Network will continue to refer uninsured and underinsured families with newborns and young children to RIte Care.

DCFHE will continue to work with its Woonsocket and Washington County CATCH partners on medical homes.

The Title X Family Planning Program will continue to provide affordable family planning services to adolescents in need of confidential services.

The DCFHE's MHPCs will continue to refer underinsured and uninsured individuals to health insurance and other resources in the community.

PRAMS will continue to survey women two to four months after delivery and will ask about their baby's health insurance status. TWOS survey will continue to include questions regarding health insurance. CHDA will continue to analyze data from the National Survey of Children's Health to determine insurance coverage among children in Rhode Island.

The Rhode Island Task Force on Premature Births will continue to advocate for supporting state policies and programs that ensure access to comprehensive primary and preventive health care services for women and children. The upholding of the National Health Care Reform Law will provide Rhode Island with new opportunities for expanding access to health insurance.

The OPCRH will continue to administer Rural Health Systems Building grants to coalitions/networks in each of the four non-metro areas of the state, to expand and enhance systems of care including strengthening partnerships between health care providers and community-based supports to increase outreach to uninsured and Medicaid-eligible populations outside urban areas.

The DCFHE will design and implement an adolescent health summit to inform near term strategies to support adolescent health statewide. A broad-based group of adolescent health partners will plan, implement, and evaluate these efforts.

The DCFHE's Refugee Health Program will continue to work to increase the increase the percentage of refugees for whom a health screening form is submitted within 30 days of the refugee's arrival.

The DCFHE will continue to support the Community Health Worker Association (CHWA) to develop a system for CHWs, including career ladders, core competency training, and higher wages. CHWs are established, yet growing health care assets in Rhode Island. CHWs will support community activation around integrative pubic health efforts. Local support and outreach programs such as PPEP, Family Resource Counselors, Americorp Volunteers, and Lifespan Community Advocates are included in the CHWA Network //2013//.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	35.9	32.3	32.3	32.1	34
Annual Indicator	34.3	33.3	33.2	34.2	32.8

Numerator	4629	4614	4754	4757	4346
Denominator	13498	13850	14303	13918	13252
Data Source	WIC Database	WIC Database	WIC Database	WIC Database	WIC Database
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	32.5	34	34.5	34	32.8

Notes - 2012
Data for 2012 is estimated.

Records with missing data (age, gender, height or weight) are excluded in both numerator and denominator.

Notes - 2011
Percentage of WIC children with BMI >= 85th percentile remained about the same from 2008 and 2011.

Records with missing data (age, gender, height or weight) are excluded in both numerator and denominator.

Notes - 2010
Percentage of WIC children with BMI >= 85th percentile remained about the same for 2009 and 2010.

Records with missing data (age, gender, height or weight) are excluded in both numerator and denominator.

a. Last Year's Accomplishments
Data Discussion
/2014/ Height and weight data are transferred daily from the WIC information system to KIDSNET //2014//. /2013/ KIDSNET programming was completed to calculate BMI and percentile using that data. In addition, a healthy weight page was programmed in KIDSNET to display a history of height and weight including an option to see the data plotted on a stature and weight for age or BMI for age chart as well as green, yellow and red color indicators for normal, overweight, and obese BMI percentiles respectively //2013//. /2104/ The WHO growth charts have replaced the weight/length charts in both KIDSNET and the WIC Program ***//2014//. /2103/ This information is available to authorized users who coordinate care for these children //2013//.***

Last Year's Accomplishments

/2013/ The IHW direction is outlined in its Eat Smart Move More Plan for Action 2010-2015, which includes objectives to:
• Enable and require licensed childcare menus that are consistent with the Dietary Guidelines for Americans
• Ensure coverage and capacity for nutrition counseling, behavioral counseling, and

patient reimbursement of weight management program costs by RI's major health insurers.
• Promote the DHHS's Business Case for Breastfeeding and recognize worksites that effectively accommodate breastfeeding mothers.

WIC works with IHW in promoting healthy foods in Providence. WIC has focused training on Client Centered techniques and reviewed staff competence through observations and trainings. WIC continued to provide WIC sites with technical assistance and training on accurate assessments regarding overweight children and follow-up. The Breastfeeding Program conducted a range of activities to educate and promote breastfeeding and provided direct breastfeeding support to women enrolled in WIC. Reduction of high BMI's was a performance measurement for WIC local agencies. WIC provided hospital grade electric pumps to fully breastfeeding women who are returning to work or school or for those with a medical necessity.

The Farmer's Market Nutrition Program continued to offer families vouchers to buy fresh fruits and vegetables each summer. WIC partnered with Johnson & Wales University to provide nutrition education classes that provided information on incorporating fruits and vegetables as part of a healthy diet. WIC continued to provide nutrition information to community partners (hospitals, health centers, daycares, Early Intervention Programs) to provide consistent messages to parents and enhance communication among community partners.

/2104/ CHDA staff worked closely with the DCFHE's IHW on issues related to data and surveillance, and analyzed data to determine trends of obesity between 2-5 year-olds participating in WIC //2014//.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supported hospitals in adopting the baby friendly hospital initiative lactation support and promtion activities.		X		
2. Modified WIC WEBS to encourage client centered counseling and trained local WIC agency staff in this technique.				X
3. Conducted the Farmers Market Nutrition Program.	X			
4. Analyzed WIC data to determine trends of obesity between 2-5 year olds participating in WIC.			X	
5. IHW conducted pediatric provider trainings to help providers identify overweight and obesity issues and provide counseling and referrals.		X		
6. Convened a Health Policy Council to initially addresses obesity prevention.				X
7. Conducted a web-based survey of Olneyville residents to assess access to healthy foods and physical activity resources.			X	
8. Supported the Lots of Hope and Sankofa programs to increase access to healthy foods and reduce disparities.				X
9.				
10.				

b. Current Activities
/2013/ DCFHE supports hospitals in adopting the Baby-Friendly Hospital Initiative, lactation support and promotion activities. Direct support and counseling is provided to breastfeeding WIC

clients.

/2104/WIC is focusing on training of client centered interviewing and continues to monitor. The Farmer's Market Program is currently underway for summer of 2013 and is partnering with Farm Fresh to increase redemptions at the Farmer's Markets ***//2014//.***

CHDA analyzes WIC data to determine trends of obesity between 2-5 year-olds participating in WIC. IHW is also conducting pediatric provider trainings to help providers identify overweight and obesity issues, counsel and refer patients and families.

DCFHE has convened a Health Promotion Policy Council made up of senior level, highly influential state and local decision makers to define a strategic legislative agenda that is initially addressing obesity prevention. /2014/ This has resulted in a food policy for HEALTH to implement during meetings and is being encouraged by other state agencies//2014//.

/2013/IHW is conducting a web-based survey of Olneyville urban community residents to assess access to healthy foods and physical activity resources //2013//.

/2014/The DCFHE's Title V-funded CHEW project includes the Lots of Hope Program to turn unused city property into urban farms and the Sankofa Program to reduce diet-related disparities and improve eating behaviors of West End residents though a neighborhood intervention //2014//.

c. Plan for the Coming Year

/2014/DCFHE will continue to work to reduce childhood obesity through IHW partnerships to build infrastructure and by promoting good nutrition through the WIC and Breastfeeding programs //2014//. The IHW is funded with a grant from the CDC for implementation of its state Plan, providing additional resources to support obesity prevention in the state. The IHW is a recipient of a 24-month CDC ARRA CPPW physical activity funds to implement a statewide model for integrating active living into all local planning decisions through policy and environment change.

The Health Promotion Policy Council will continue to advance a strategic legislative policy agenda to address obesity prevention, including addressing regulation of the nutrition in child care centers.

/2014/ The DCFHE will continue to lead the state's breastfeeding promotion initiatives, including the Baby-Friendly Hospital Initiative and education and training for all health care professionals who care for women and children. The DCFH will also continue to provide support and counseling to breastfeeding WIC clients. The DCFHE will use community based organizations, including First Connections and MIECHV programs, to promote and support breastfeeding //2014//.

DCFHE, Kids First organization, and the RI Department of Education will continue to provide technical assistance to School District Health and Wellness Subcommittees to improve school environments to support better nutrition and more physical activity.

WIC staff will continue to provide additional training on VENA and client centered counseling and will monitor counseling strategies in the clinics.

/2014/ WIC will partner with Farm Fresh in the Farmer's Market Nutrition Program. WIC staff will educate WIC participants about increasing fruit and vegetable consumption. WIC has authorized Farmers' Markets to accept the cash value voucher for fruits and vegetables //2014//.

/2103/ The WIC Parent Consultant will continue to interview WIC participants regarding their perception of and experiences with WIC nutrition education services. This information will be shared with local WIC agencies to help them improve the nutrition education services they provide and identify staff training needs.

CHDA staff will continue to work on analyzing WIC data to determine trends of obesity between 2-5 year-olds participating in WIC.

The new Child Health Consultants will coordinate with WIC and refer children in childcare, and their families who would benefit from WIC.

Diabetes Prevention and Control plans to continue through the efforts of the work group to coordinate with the IHW to prevent childhood obesity and the development of type 2 Diabetes //2013//.

/2014/The DCFHE's Title V-funded CHEW project includes the Lots of Hope Program to turn unused city property into urban farms and the Sankofa Program to reduce diet-related disparities and improve eating behaviors of West End residents though a neighborhood intervention //2014//.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	12.9	11.4	11	9.5	9.7
Annual Indicator	10.8	9.4	9.7	9.7	9.6
Numerator	1205	1013	1033	996	699
Denominator	11166	10734	10602	10274	7280
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	9.2	9.2	9.2	9	9

Notes - 2012
Data are estimated and reflect births for May to December 2012.

Data collection for 2012 PRAMS will not be completed until end of June 2013 and the weighted data will not be available until the fall 2013.

Notes - 2011
Rhode Island PRAMS shows the percent of women who smoked in the last three months of pregnancy remains about the same for 2009 thru 2011

Notes - 2010
Rhode Island PRAMS shows the percent of women who smoked in the last three months of pregnancy remains about the same for 2009 and 2010.

a. Last Year's Accomplishments
Data Discussion
/2013/ According to 2010 PRAMS data 9.7% percent of women reported smoking in their last trimester. While the rate has been trending down since 2006, pregnant women remain a priority in terms of priority populations for reducing tobacco use, due to multiple vulnerabilities faced by both women, their unborn children, and other children in the home. While the decreasing rate is promising, disparities still remain among subgroups of pregnant women. For example, rates of smoking during pregnancy vary significantly by age, educational level, marital status, race/ethnicity, household income, and health insurance. The DCFHE continues to develop, support, and review a variety of prevention and screening activities and will continue its efforts to reduce smoking during pregnancy, particularly among at-risk populations //2013//.

a. Last Year's Accomplishments

/2013/ The DCFHE supported the Tobacco Control Program (TCP) to conduct a variety of activities to prevent children from ever starting to use tobacco and to help smokers and users of smokeless tobacco quit. The Tobacco Control Program administered the toll-free smokers' helpline (telephone Quit Line, 1-800-QUIT-NOW), which directed smokers and/or those who care about smokers to the cessation program that will work best for them including a choice of information materials, web-based counseling, or telephone counseling.

The Department's Health Information Line referred callers with questions about smoking to 1-800-QUIT-NOW.

The CHDA continued to conduct PRAMS and determine the percentage of respondents who reported they had smoked during the last trimester of their pregnancy.

The DCFHE participated on the Rhode Island Task Force on Premature Birth. One of the Task Force's recommendations is to "support statewide tobacco and nicotine cessation programs and media campaigns to ensure access for all women of reproductive age with emphasis on pregnancy." Through the participation of the Tobacco Control Program's Cessation Coordinator, ongoing dialogue, stateside coordination, collaboration and linkages took place //2013//. ***/2014/ The Task force has also identified through state data, smoking as a core risk associated with prematurity and is developing a provider tool recommending that it be assessed and included in preconception counseling for all patients of reproductive age //2014//.***

/2013/First Connections provided families with information about the dangers of tobacco use and second hand smoke and referred women and other family members who smoke to tobacco cessation services //2013//.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Partnered with Health Centric Advisors on health systems change efforts in RI.				X
2. Supported the Quitline and website.			X	
3. Supported the Task Force on Premature Births to support statewide tobacco cessation programs and media campigns to support pregnant women who smoke.				X
4. Supported First Connections and MIECHV home visiting	X			

programs to provide families with information about the dangers of tobacco use and second hand smoke and to make referrals to tobacco cessation services.				
5. Conducted outreach to pregnant women in WIC.		X		
6. Analyzed PRAMs data on women who smoke during pregnancy.			X	
7.				
8.				
9.				
10.				

b. Current Activities

/2013/ DCFHE is partnering with Health Centric Advisors (HCA) on health systems change efforts in RI. HCA conducts outreach to Women and Infants Hospital, the premier birthing hospital in the state, to encourage them to systemically adopt brief tobacco cessation intervention protocols.

The DCFHE continues to support the TCP to conduct prevention and cessation activities and to administer the Quitline and website http://www.quitnowri.com/ providing information for those who want to quit.

The DCFHE, in partnership with Women & Infants Hospital, is currently working with the RI Task Force on Premature Births to support statewide tobacco and nicotine cessation programs and media campaigns to ensure access for all women of reproductive health age with an emphasis on pregnant women who smoke. One work group pf the Task Force is working to develop a universal preconception screening tool.

The First Connections and MIECHV programs provide families with information about the dangers of tobacco use and second hand smoke and refer them to smoking cessation resources in the community.

Outreach to at-risk pregnant women continues to occur in WIC sites across the State. At-risk pregnant women who do not meet the eligibility criteria for other programs may be referred to First Connections.

CHDA conducts RI PRAMS and analyzes data on women who smoke during pregnancy //2013//.

c. Plan for the Coming Year

/2013/ The DCFHE RI Tobacco Control Program will continue to administer the Quit Line and webpage http://www.quitnowri.com/.

DCFHE will support TCP efforts to prevent young women from initiating smoking by using Title V funds to build state capacity to enforce laws related to tobacco sales to minors. Additional work will continue to be done to educate decision makers on how to improve coordination of services for at risk communities and identify and provide comprehensive services to improve outcomes for families that reside in at risk communities.

First Connections & MIECHV programs will continue to provide families with information about the dangers of tobacco use and second hand smoke and will refer them to smoking cessation resources in the community. ***/2014/ The TCP will continue to provide training to new home visiting staff on tobacco products and cessation services //2014//.***

CHDA will continue to conduct PRAMS and analyze data on women who smoke during pregnancy.

A data collection protocol associated with First Connections home visitors will provide data for the KIDSNET data system at HEALTH. The data will be analyzed in order to provide information on how many clients smoke and how many receive referrals and follow up on referrals. This added analysis will help to close the loop on the brief tobacco cessation intervention that is currently taking place, as currently there is no mechanism for verifying whether clients have been referred, whether they have followed up on the referral, and what the cessation attempt outcomes are. While the brief tobacco cessation protocols have been developed, the ability to retrieve and utilize the data will be developed in the upcoming year //2013//.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	3.7	3.7	1	1	1.7
Annual Indicator					
Numerator					
Denominator	79678	80046	80046	80046	80046
Data Source	Vital Records Death File	Vital Records Death File	Vital Records Death File	Vital Records Death File	Vital Records Death
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Provisional	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	1	1	1	1	1

Notes - 2012
Provisional data for 2012 reports 3 events and a total of 11 events for 2010 thru 2012. Therefore, there are lt 5 events for the year and the average of the last 3 years is also lt 5 events.

Denominator from 2010 Population Census.

Notes - 2011
Provisional data for 2011 reports 4 events and a total of 12 events for 2009 thru 2011. Therefore, there are lt 5 events for the year and the average of the last 3 years is also lt 5 events.

Denominator from 2010 Population Census.

Notes - 2010

For 2010 there were 4 events and a total of 12 events for 2008 thru 2010. Therefore, there are lt 5 events for the year and the average of the last 3 years is also lt 5 events.

Denominator from 2010 Population Census.

a. Last Year's Accomplishments

Data Discussion

Youth suicide is a serious but largely preventable public health problem. After falling over 28% during the period 1990-2003, suicide rates in America for males and females aged 10-24 climbed 8% in 2004, the largest single one-year rise in 15 years. Although youth suicide rates have dropped slightly since 2004, they remain above predicted levels. Suicide is the 3rd leading cause of death among youth 15-24 years of age in Rhode Island (RI) and the nation.

a. Last Year's Accomplishments

/2013/ With support from a three-year Substance Abuse & Mental Health Services Administration (SAMHSA) grant (2008-2011), Safe Rhode Island's Youth Suicide Prevention Project was able to successfully apply for a second three-year grant (2011-2014). Using these grants, the Rhode Island Youth Suicide Prevention Project has established the infrastructure to support the implementation of a comprehensive, multifaceted suicide prevention and early intervention program for adolescents and youth adults aged 15-24 in Rhode Island's core city high schools and community-based organizations. The objective is to connect a minimum of 400 youth with new or enhanced services over the next three-year grant period. The Rhode Island Youth Suicide Prevention Project (RIYSPP) successfully: 1) Trained 1858 gatekeepers in the six core cities targeted for intervention in Question, Persuade, Refer (QPR) evidence based prevention program; 2)Identified 290 at risk youth, provided referrals for services, and documented access to services for youth identified; 3) Secured commitment and began implementing the American Foundation for Suicide Prevention's Interactive Screening Program at the University of Rhode Island. 4) Assessed referral resources and created and disseminated a Community Resource Guide. 5) Trained 123 youth in the Signs of Suicide (SOS) evidence-based peer gatekeeper training program in Providence high schools and community-based organizations; 6) Conducted a means-restriction awareness campaign utilizing radio and television PSA's targeting parents of youth aged 15-24 in the core cities; 7) Secured commitment from graduate level course "Injury as a Public Health Problem" at Brown University to include suicide prevention coursework in Fall 2012; 8)Built online suicide prevention educator resource in conjunction with Brown University entitled "Suicide Prevention Information and Resources for Educators" to encourage graduate level Public Health and Medical School faculty to integrate suicide prevention into their courses in order to educate the future workforce about suicide as a preventable public health problem //2013//.

The DCFHE Office of Special Health Care Needs (OSHCN) added a disability indicator to the Youth Behavior Risk Survey (YRBS) to enable comparison of YSHCN with their typical peers. Data demonstrated that YSHCN engage in significantly riskier behaviors and experience more depression than their peers. The OSHCN made this data available to several intervention providers and educators. DFCHE also included a sexual orientation question and analysis of that data revealed significant differences in most of the health risks. DFCHE participated in the LGBTQQ Task Force to support best practices related to these health risks.

/2013/ DCFHE supported Washington County and Woonsocket CATCH projects on adolescent medical homes //2013//.

The DCFHE managed thrive, in partnership with the RI Department of Education. This partnership focused on strengthening the statewide infrastructure to address school guidance, counseling, and social services; school environment; and school climate to assure safe, caring, and nurturing schools.

DCFHE personnel continue to participate on the Child Death Review Team led by the State Medical Examiner, which reviews child deaths to determine whether they were preventable. Suicides are included in these reviews. CHDA analyzed Vital Statistics death file data to track the rate of suicides among teens.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implemented the RI Youth Suicide Program.				X
2. Supported First Connections and MIECHV home visiting programs to assess teen mothers for depression and refer them for evaluation and treatmen.	X			
3. Participated on the Child Death Review Team.			X	
4. Analyzed YRBS data.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2013/ The RI Youth Suicide Prevention Program includes: Question, Persuade, Refer (QPR) adult gatekeeper training, Signs of Suicide (SOS) youth gatekeeper training, the American Foundation for Suicide Prevention (AFSP) Interactive Screening Program (ISP) an internet-based self administered screening tool to identify students at risk and refer them to their college counseling center for follow-up, integration of suicide prevention course content in Brown University's MPH and medical clerkship curricula, and a statewide lethal means restriction media campaign //2013//.

First Connections & MIECHV assess teen mothers of newborns and/or young children for depression and refers those that may be at risk for depression for mental health evaluation and treatment services.

DCFHE participates on the Child Death Review Team and analyzes Vital Statistics death files. YRBS data tracks teen suicide rates, and related indicators.

/2013/ DCFHE continues to support Washington County and Woonsocket CATCH projects.

Addressing the emotional "literacy" needs of young children is the foundation for perceiving and communicating emotions and establishing health relationships later in life. Using DCFHE rural health funding, the Washington County Coalition for Children is implementing its "Feeling Groovy" campaign with rural 2nd graders using a lesson plan based on the award-winning book "The Way I Feel". Students also design a bookmark illustrating their feelings //2013//.

c. Plan for the Coming Year

/2013/ In the coming year, the RI Youth Suicide Prevention Program will implement: QPR to train a minimum of 425 additional adults in schools and community-based organizations and will as expand QPR training to at least 1 new community high school in RI, SOS to train a minimum of 150 additional youth in schools and community-based organizations in the core cities, AFSP ISP

in a minimum of 1 additional RI college/university, integration of suicide prevention course content in a minimum of 2 additional courses within the Brown University's Master of Public Health and medical clerkship curricula, and a statewide lethal means restriction media campaign //2013//.

The DCFHE SafeRI Violence and Injury Prevention Program will expand implementation of the SAMHSA grant to address teen suicide prevention to reach non-core MCH planning cities that have high rates of teen suicide (
East Providence and Cranston). The program will be expanded to identify young veterans and young people on active military duty and to reach young people in the RI Training School. A media campaign supporting this effort will also be implemented in participating cities.

The DCFHE will also continue leading the state suicide prevention task force.

The DCFHE will continue to participate on the Child Death Review Team. The DCFHE will continue to analyze data from Vital Statistics death files and the Youth Risk Behavior Survey.

The OSHCN will continue to review youth engagement and risk behavior to assess the specific needs of youth with special health care needs. The Office will continue to provide youth opportunities for healthy development, acquiring coping skills and increasing protective factors in youth with special health care needs.

DCFHE will continue to work with the RI Association of School Principals and the RI AAP on strategic activities to link the work of the two organizations to support health and academic achievement among school aged children. /2013/ The DCFHE in partnership with the RI Association of School Principals developed a mental health toolkit aligned with professional development. The toolkit will continue to be offered to school administrators //2013//.

First Connections & MIECHV will continue to assess teen mothers of newborns and/or young children for depression and refers those that may be at risk for depression for mental health evaluation and treatment services.

CHDA will conduct and analyze the YRBS data to collect information on issues related to suicide (intent, attempts, etc.).

The DCFHE will continue to manage Thrive, in partnership with the RI Department of Education.

/2013/ DCFHE will continue to support Washington County and Woonsocket CATCH projects. The Washington County Coalition for Children will continue to implement its "Feeling Groovy" campaign for 2nd graders //2013//.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	92.8	94.5	94.5	93	93.7
Annual Indicator	93.6	92.6	91.5	93.2	92.7
Numerator	161	174	151	150	165
Denominator	172	188	165	161	178
Data Source	Vital Records	Vital Records	Vital Records	Vital Records	Vital Records

	Birth File	Birth File	Birth File	Birth File	Birth File
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	93	93.6	95.6	95.6	93

Notes - 2012
Provisional data for 2012 shows a slight decrease which is not significant.
Numerator reflects VLBW resident infants born at Women & Infant's Hospital. The Denominator reflects all VLBW resident infants born in all of the Rhode Island hospitals.
Hospital of birth is not entered for Rhode Island resident births occurring out-of-state

Notes - 2011
Data for 2011 shows a slight increase which is not significant.
Numerator reflects VLBW resident infants born at Women & Infant's Hospital. The Denominator reflects all VLBW resident infants born in all of the Rhode Island hospitals.
Hospital of birth is not entered for Rhode Island resident births occurring out-of-state

Notes - 2010
Data for 2010 shows a slight decline which is not significant.
Numerator reflects VLBW resident infants born at Women & Infant's Hospital. The Denominator reflects all VLBW resident infants born in all of the Rhode Island hospitals.
Hospital of birth is not entered for Rhode Island resident births occurring out-of-state.

a. Last Year's Accomplishments
Data Discussion
/2013/ Women & Infants Hospital is the regional perinatal center for Rhode Island and all of southeastern New England and serves as the primary location for high-risk deliveries. The Neonatal Intensive Care Unit (NICU) at Women & Infants Hospital in Providence, serves as the sole Level III NICU in Southeastern New England. The majority of infants admitted to the NICU are low birth weight, premature infants //2013//. ***/2014/ In 2012, 92.7% of very low birth weight infants were born at this hospital //2014//.***

Last Year's Accomplishments

The DCFHE is committed to ensuring that high-risk mothers deliver at Women & Infants Hospital, so that appropriate, comprehensive, and expert care can be provided through their NICU.

/2013/ The Family Planning Program provided no cost pregnancy testing and preconception counseling to women in federally funded Title X family planning clinics; those with negative pregnancy tests were provided with family planning services; those with a positive pregnancy test were referred to prenatal care and other community-based supports early in pregnancy //2013//.

A RI Task Force on Premature Birth recommendation focused on developing a coordinated

medical home for preterm infants and their families at Women & Infants Hospital's NICU. The CHIP (Comprehensive Health Integration for Premies) Program, now called Transition Home Plus, has been implemented and has been successful in decreasing re-hospitalization rates and emergency room usage. Another recommendation focused on implementing changes to the vital statistics birth record to include methodology used to calculate gestational age and the use and type of fertility treatment(s) to achieve pregnancy. The Office of Vital Records started collecting this new data for babies born effective February 2010.

DCFHE continues to support the implementation of prenatal home visiting in Rhode Island. The First Connections Home Visiting Program offered services on a limited basis to at-risk pregnant women and connected them to prenatal care and other community resources and supports. Outreach to pregnant women in local WIC offices began in the winter of 2010.

A pediatric developmental physician worked as a consultant for the DCFHE at the Hasbro Children's Hospital Children's Neurodevelopmental Center providing training to personnel at the Women & Infants' NICU to help ensure that high-risk infants were referred to the Early Intervention Program prior to discharge. Physician materials developed by the DCFHE for the Early Intervention Program were provided to NICU staff.

Families with infants born weighing 1,500 grams or less are offered Part C Early Intervention services as well as the Transition Home Plus Program at discharge. Transition Home Plus a specialized care program to transition NICU graduates into primary care and is focused on high-risk, very low birth weight infants (less than 1,500 grams) with complex special health care needs. Project outcomes include decreasing the rates of emergency room visits and re-hospitalizations.

/2013/ The DCFHE placed a PPEP Parent Consultant in the Women and Infants' NICU to review community resources available to families upon discharge and provides training to NICU personnel to help ensure that high-risk infants are linked to the Early Intervention Program and other programs as appropriate. The PPEP at Women & Infant's Hospital Neonatal Follow-up Clinic provides assistance to families of at-risk newborns through peer support services, systems navigation, and family-to-family linkages.

The DCFHE engages community partners and began development of a preconception health strategic plan to enhance the health of all Rhode Islanders and to maximize health pregnancies and outcomes //2013//.

The RI Task Force on Premature Births developed and implemented an educational campaign for providers and patients addressing previous preterm birth. Providers were encouraged to assess the risk for preterm birth with each pregnant woman during prenatal care. If a previous preterm birth is documented, 17-hydroxyprogesterone caproate (17-OHP) may be offered.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supported First Connections and MIECHV home visiting programs.	X			
2. Supported the Task Force on Pemature Births.				X
3. Supported the Family Planning Program to provide no cost pregnancy testing, preconception counseling, and referrals to women receiving pregnancy testing.	X			
4. Supported a statewide preconception health plan to address preconception health through implementation in health care practices and promotion, comprehensive health policies, and public health initiatives.				X

5. Implemented the birth certificate worksheet which includes fertility questions.			X	
6. Supported the PPEP parent consultant in the NICU to assure that infants are linked to Early Intervention.		X		
7. Supported the PPEP at the Neonatal Follow-up Clinic to provide assistance to families of at risk newborns through peer support services, systems navigation, and family to family linkages.		X		
8. Supported the Newborn Screening Program's thyroid protocol to identify infants with delayed hypothyroidism and ensure proper treatment and follow-up.			X	
9.				
10.				

b. Current Activities

/2013/ First Connections and MIECHV provide home visiting services to mothers of newborns with a stay in the NICU and provide them with information and education designed to prevent another high risk birth. Home visitors refer mothers with risk factors to appropriate community resources.

DCFHE supports the Task Force on Premature Births, which continues to work to reduce premature births in Rhode Island.

Family Planning continues to provide no-cost pregnancy testing, preconception counseling, and referrals to women receiving pregnancy testing in Title X family planning agencies //2013//.

/2014/ DCFHE and March of Dimes hosted a statewide Preconception Health Summit to provide strategies to integrate preconception health into policy, programs, and practice and move forward the state's preconception health strategic plan. Attendees included Rhode Island leaders in human services, education, and multi-disciplinary health care professions. //2014//.

The new birth certificate worksheet includes fertility questions.

/2013/OSHCN continues to support the PPEP Parent Consultant in the NICU to help ensure that high-risk infants are linked to EI. The PPEP at the Neonatal Follow-Up Clinic provides assistance to families of at-risk newborns through peer-support services, systems navigation, and family-to-family linkages //2013//.

RI's Newborn Screening Program initiated a new thyroid protocol to identify infants with delayed hypothyroidism and ensure proper treatment and follow-up.

c. Plan for the Coming Year

/2013/ First Connections and MIECHV will provide home visiting services to mothers of newborns with a stay in the NICU and provide them with information and education designed to prevent another high risk birth. Home visitors will refer mothers with risk factors to appropriate community resources.

DCFHE will continue to support Title X family planning agencies to make referrals to prenatal care and other community-based supports early in pregnancy //2013//.

/2014/ DCFHE will continue to work with the Preconception Health Collaborative which includes health care providers, allied professionals, insurers, consumers, policy makers and other key stakeholders to begin implementation of the statewide Preconception Health

Strategic Plan to improve pregnancy outcomes //2014//.

Families born with infants born at very low birth weight (less than 1,500 grams) will continue to be offered Part C EI services, as well as, the Transition Home Plus Program at discharge. Transition Home Plus, a specialized care program to transition NICU graduates into primary care, focused on high-risk very-low birth weight infants with complex special health care needs. Project outcomes include decreasing the rates of emergency room visits and re-hospitalizations. The RI Task Force on Premature Birth will identify and implement strategies to support the progress of the Transition Home Plus Program.

The PPEP Parent Consultant working in the NICU /2013/ and the Neonatal Follow-up Clinic //2013// will continue to provide assistance to families in accessing community resources. /2013/ The PPEP will provide training to NICU personnel on family centered care practices and community linkages //2013//. DCFHE will work with KIDSNET to print a monthly report of infants born at 1,500 grams or less who have been referred to Early Intervention and have not engaged in services.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(ii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	82.5	84.5	85.4	86.7	88
Annual Indicator	81.9	85.2	86.5	87.9	87.9
Numerator	9539	9471	9399	9169	9126
Denominator	11651	11120	10868	10427	10385
Data Source	Vital Records Birth File	Vital Records Birth File	Vital Records Birth File	Vital Records Birth File	Vital Records Birth File
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	88.2	87.9	87.2	87.2	88.2

Notes - 2012
Provisional data for 2012 reflects calendar year. Percent of infants born to women receiving prenatal care in the first trimester remained the same for 2011-2012.
Birth records with unknown month of prenatal care are excluded.

Notes - 2011
Data for 2011 reflects calendar year.

Data shows an increase from 86.5% in 2010 to 87.9% for women receiving prenatal care in the first trimester. There has been a slight increase each year since 2008.

Birth records with unknown month of prenatal care are excluded.

Notes - 2010
Data for 2010 reflect calendar year.

Data reflect an increase from 81.9% in 2008 to 86.5% for women receiving prenatal care in the first trimester.

a. Last Year's Accomplishments
Data Discussion
According to PRAMS data, the percentage of infants born to pregnant women receiving prenatal care beginning in the first trimester has remained about the same since 2009. Disparities remain among sub-populations; the DCFHE will continue to support integrated efforts that ensure early access to care for pregnant women, with special focus on at-risk populations.

a. Last Year's Accomplishments
The DCFHE continued efforts to ensure that high-risk mothers and newborns are provided the appropriate level of care to support their unique needs. The NICU at the Women & Infants Hospital will continue to provide Level III subspecialty care to these women and their newborns.

/2013/The DCFHE funded a Gestational Diabetes Mellitus (GDM) pilot project with Women & Infants Hospital of Rhode Island (WIHRI) and Providence Community Health Centers for the early identification, referral, and/or treatment of women who are diabetic, pre-diabetic, or at risk of developing diabetes. The WIHRI Registered Nurse identified women with gestational diabetes who attended the WIHRI pre-natal clinic and provided education about controlling blood glucose and the importance of post-partum testing. She continued to follow these women until they returned for an oral glucose tolerance test (OGTT). A Patient Navigator provided the same services for women with gestational diabetes who received their prenatal care at PCHC. These efforts resulted in an almost 20% increase in the number of women who returned for the post-partum OGTT -from 44% to 63% in the first year of the project.

The DCFHE supported the Family Planning Program, which provides no-cost pregnancy testing and preconception counseling to women receiving services in federally-funded Title X family planning clinics. Through the program, pregnant women with identified health risks will be referred to prenatal care and other community-based supports early in pregnancy //2013//.

The PPEP Parent Consultant working in the NICU continued to provide assistance to families in accessing community resources and provided training to NICU personnel to help ensure that high-risk infants are linked to the Early Intervention Program prior to discharge.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supported the Gestational Diabetes Mellitus pilot project for the early identification, referral, and treatment of pregnant women who are diabetic, pre-diabetic, or at risk of developing diabetes.	X			
2. Supported the Family Planning Program which refers newly	X			

identified pregnant women to prenatal care.				
3. Supported the Task Force on Premature Births to develop a universal risk assessment and referral tool for pregnant women.				X
4. Supported the MIECHV Program to work with pregnant women to ensure that they enter and remain in prenatal care.	X			
5. Analyzed PRAMS and Newborn Developmental Risk Screening data to determine adequacy of prental care among pregnant women.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2013/The DCFHE continues to support the GDM pilot project to improve the percentage of women with gestational diabetes who return for the OGTT and are referred to appropriate pre-diabetes or diabetes services.

The Family Planning Program continues to provide no-cost pregnancy testing and preconception counseling to women receiving services in Title X family planning clinics with referrals made to prenatal care/community-based supports early in pregnancy //2013//.

/2014/ The DCFHE is working closely with the RI Task Force on Premature Births to develop a universal preconception risk assessment and referral tool //2014//.

/2013/The DCFHE, in conjunction with external partners, is finalizing a statewide preconception health plan to systemically address preconception health through the implementation of health care practices and promotion, comprehensive health policies, and public health initiatives //2013//.

The toll-free bi-lingual Health Information Line continues. Culturally and linguistically appropriate informational materials are distributed through the Distribution Center.

CHDA continues to administer the PRAMS survey, and Newborn Developmental Risk Screening data are collected and analyzed regarding the adequacy of prenatal care among pregnant women.

/2013/ MIECHV programs work with pregnant women to assure that they enter and remain in prenatal care //2013//.

c. Plan for the Coming Year

/2013/The DCFHE will continue to support the GDM pilot project to improve the percentage of women with gestational diabetes who return for the OGTT and are referred to appropriate pre-diabetes or diabetes services.

The Family Planning Program will continue to provide no-cost pregnancy testing and preconception counseling to women receiving services in Title X family planning clinics with referrals made to prenatal care/community-based supports, including home visiting, early in pregnancy //2013//.

/2014/ The DCFHE will work closely with the RI Task Force on Premature Births to develop and implement a universal preconception risk assessment and referral tool.

Through development and introduction of the state's Preconception Strategic Plan, the DCFHE has formulated a Preconception Health Collaborative consisting of a wide variety of community partners. The collaborative will convene in the Fall of 2013 to systematically address preconception health through implementation of health care practices and promotion, comprehensive health policies, and public health initiatives. Provide education and increase access to confidential care for adolescent are two strategy areas in the plan //2014//.

The toll-free bi-lingual Health Information Line will continue. Culturally and linguistically appropriate informational materials will continue to be distributed through the Distribution Center.

CHDA continues to administer the PRAMS survey, and Newborn Developmental Risk Screening data are collected and analyzed regarding the adequacy of prenatal care among pregnant women.

/2013/ MIECHV programs will continue to work with pregnant women to assure that they enter and remain in prenatal care //2013// ***/2014/ per the recommended number of visits using the Kotelchuck Index and use the data to provide information to tailor services to high risk populations //2014//.***

D. State Performance Measures

State Performance Measure 1: *The percent of Rhode Island resident families with at risk newborns that recieve a home visit during the newborn period (<=90 days)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				52.2	55.2
Annual Indicator	45.0	45.1	48.6	52.0	50.3
Numerator	3165	3086	3298	3458	3408
Denominator	7030	6840	6788	6652	6769
Data Source	Newborn Screening	Newborn Screening	Newborn Screening	Newborn Screening	Newborn Screening
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	53	55	58	61.2	61.2

Notes - 2012
Provisional data for 2012 reports a slight decrease in home visiting to risk positive infants. About 50% received home visits in 2012 compared to 52% in 2011.

In 2012, 3,361 infants\women eligible for home visits did not receive a home visit. Those that did not receive a home visit include those that refused the service and those that could not be located.

Notes - 2011

Data for 2011 reports a slight increase in home visiting to risk positive infants. About 52% received home visits in 2011 compared to 48.5% in 2010.
In 2011, 3,265 infants\women eligible for home visits did not receive a home visit.

Notes - 2010
Data for 2010 reports a slight increase in home visiting to risk positive infants. About 48.6% received home visits in 2010 compared to 45.4% in 2009.
In 2010, 3,510 infants\women eligible for home visits did not receive a home visit. Of the total, 1736 families refused a home visit and 1436 could not be located.

a. Last Year's Accomplishments
/2013/ KIDSNET captured information about developmental risk factors that trigger a referral for a home visit as well as home visiting data. As evidence-based- home visiting programs are implemented, KIDSNET will be enhanced to capture additional data from these home visiting programs //2013//. ***/2014/ About half of all families with at risk newborns receive home visits //2014//.***

/2013/ DCFHE supports a continuum of home visiting services including evidence-based parent education and family support. Expanding home visiting programs will help to improve and strengthen programs and activities carried out under Title V, improve coordination of services to improve outcomes for families at risk //2013//. ***/2014/ HEALTH was awarded HRSA - Maternal, Infant and Early Childhood Home Visiting Program funds to expand capacity within the state to provide evidence-based home visiting services.***

HEALTH contracts with four community based agencies to provide First Connections home visiting services for families of newborns that may be at risk for poor outcomes. First Connections is a statewide program that provides support to families and their children during the early years of childhood development by giving them the information and services they need to be as healthy as possible //2014//.

/2013/ Home visiting provides general parenting info, home assessments, infant care education, and links families to appropriate resources. Home visiting also serves as follow-up for Newborn Screening, Lead Poisoning Prevention, and Immunization Programs. Community partners can refer older children (aged > 3) for home visiting services. First Connections links with local WIC sites to engage families that may initially refuse home visiting services //2013//.

/2014/ Healthy Families America and Nurse Family partnership are log-term evidence-based home visiting programs that provide long-term home visiting to pregnant women and families with young children in the six communities in Rhode Island most at risk for poor outcomes. These programs help women have a healthy pregnancy and baby, understand how their child plays, grows, and learns, find a medical home, get help with breastfeeding, and connect with child care, food, and nutrition and child development services //2014//.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Captured information through KIDSNET about developmental risk factors that trigger a referral for a home visit as well as home visiting data.			X	
2. Supported First Connections to provide home visiting services to at risk families with newborns.	X			
3. Prepared and submitted a grant to HRSA MCHB MIECHV Program to provide evidence-based home visiting services to				X

pregnant women and families with young children (including newborns) in communities at risk for poor outcomes.				
4. Linked First Connections and WIC to engage families that may have initially refused home visiting services.	X			
5. Work to integrate the CHEW Project's Incredible Years parenting groups with mome visiting programs and services.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

DCFHE continues to support First Connections. In addition, the DCFHE was awarded MCHB Maternal, Infant, and Early Childhood Home Visiting (MIECHV) funding to implement three evidence-based home visiting programs for pregnant women and families with children up to age three in the state's six urban core communities. The three evidence-based models being implemented are Nurse Family Partnership, Healthy Families America, and Parents as Teachers. ***/2014/ Significantly, the MIECHV funding allows the DCFHE to expand home visiting services to pregnant women and provide services to women who need more long-term support. MIECHV infrastructure includes a Home Visiting Leadership Council, Local Implementation Teams, Community Coalitions, and a Home Visiting Network. In 2013, HEALTH began using Efforts to Outcomes (ETO) to capture data on pregnant women and mothers and young children enrolled in Healthy Families America and Parents as Teachers. Nurse Family partnership also uses ETO and has done so since the program began in Rhode Island in 2010. DCFHE is working to identify ways to link the Title V-funded CHEW project's Incredible Years parenting group with home visiting programs in Providence and Pawtucket/Cental Falls //2014//.***

c. Plan for the Coming Year

/2014/ DCFHE will continue to support First Connections and the three evidence-based MCHB MIECHV programs in FY2014. DCFHE will continue to work to identify ways to link the Title V-funded CHEW project's Incredible Years parenting group with home visiting programs in Providence and Pawtucket/Cental Falls //2014//.

State Performance Measure 2: *Percent of middle school students who have initiated tobacco use.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(ii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective				16.5	16.2
Annual Indicator	16.2	17.0	17.2	16.5	16.5
Numerator	5035	5248	5345	4395	4395
Denominator	31167	30847	30995	26557	26557
Data Source	YRBS	YRBS	YRBS	YRBS	YRBS
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	16.2	16	16.7	16.2	16.5

Notes - 2012

Data are estimated. The YRBS is conducted every other year and will be conducted next during the 2013 school year.

Notes - 2011
Data for 2011 shows a slight decline, from 17% in to 2009 to 16.5% in 2011, in the percent of middle school students who initated tobacco use.

Notes - 2010
Data are estimated. The YRBS is conducted every other year and the YRBS for middle schools began with 2007.

a. Last Year's Accomplishments
/2014/ The initiation rate for middle school youth is 16.5%. CDC Promotes comprehensive tobacco control programming because the set of strategies that will prevent youth initiation are many and diverse. The field of Tobacco Control has historically been a leader in public health as relates to policy, systems, and environmental changes that improve public health outcomes. The Rhode Island Tobacco Control Program (TCP) has a history of success with dramatically decreasing the youth smoking prevalence rate. Rhode Island has decreased its high school youth smoking rate from 35% in 1998 to 11% in 2011. This represents a decrease of 68%. Rhode Island has been and continues to be a national leader in tobacco control with the third lowest youth smoking rate in the US as of the 20011 YRBS data. TCP successes are attributable to the policy, systems and environmental change initiatives in which the TCP and its community-based partners have been engaged. For example RI has the second highest tax rate in the US on cigarettes, a comprehensive ban on indoor smoking, and a law that prohibits the sale of tobacco to minors. We know from national literature that 80-90% of adult smokers begin before the age of 18 and we know that the younger a smoker initiates, the harder it is for that smoker to quit and the more likely s/he will become an established smoker. Thus, it is critical to prevent youth from ever initiating smoking.

Despite Rhode Island's successes, tobacco-related disparities do exist, particularly among groups with low household income, low levels of education, African Americans, pregnant women, people who are LGBT, aged 18-24 years old, and people who are mentally ill. Despite our relatively low smoking rates, we will continue to aggressively protect our youth from initiation and will continue to use CDC's recommended evidence-based best practice and promising practice strategies to reduce tobacco initiation and use in disparately impacted communities as well as statewide.

An additional challenge the TCP is addressing is the tobacco industry's ever-vigilant responses to the tactics of tobacco control. The tobacco industry currently has a campaign to initiate youth to tobacco products through youth-targeted emerging tobacco products such as fruit-flavored cigarillos, dip, and other non-cigarette products that are packaged very attractively with colorful wrappings and slick packages. Through the emerging tobacco and nicotine products, youth get hooked on the nicotine and become users of both cigarettes and other tobacco products. To prevent such youth initiation, Rhode Island is working to provide data and information to community-based stakeholders and decision makers. With the data we provide, these grass-roots residents and community and state leaders work to help foster systems and environmental changes that protect youth not only from cigarettes, but also from emerging tobacco products.

One such community collaboration is the partnership the Tobacco Control Program has with the City of Providence in which we partnered, through the Communities Putting Prevention to Work funding opportunity, to run an education campaign that ultimately resulted in the Providence City Council passing several point of sale policies aimed at protecting youth. All of the point of sale policies are enforceable on the local level. One policy bans flavored tobacco products from being sold in the city of Providence. Another policy bans the sale of loose cigarettes, as "loosies" are cheap and thus accessible to the youngest possible users. Another policy, aimed at reducing youth access to tobacco, was

to prohibit all tobacco use on all Providence school campuses including use by staff and all visitors. These changes in the retail and school environments will help to further de-normalize tobacco as a socially accepted product.

To further address the prevention of youth initiation, the Tobacco control Program successfully carried out a youth media campaign, "Be An Original", a youth anti-tobacco media campaign, beginning February, 2012. The media strategy targeted youth ages 12 to 17 in order to: (1) engage RI youth on topics including deceptive marketing practices, the health effects of traditional and other/emerging tobacco products; (2) develop "Be An Original" brand recognition among Rhode Island youth; and (3) provide youth with opportunities to join the tobacco control movement //2014//.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supported YRBS to collect and analyze data to track this indicator.			X	
2. Implemented the second highest tax on tobacco in the nation.			X	
3. Implemented a comprehensive ban on indoor smoking.			X	
4. Implemented a prohibition of the sale of tobacco to minors.			X	
5. Collaborated with the City of Providence on implementing a Communities Putting Prevention to Work initiative.			X	
6. Implemented a youth media campaign.			X	
7.				
8.				
9.				
10.				

b. Current Activities

/2014/TCP continues to work with its community-based partners and with the RI Tobacco Control Network to educate statewide stakeholders about the dangers of all tobacco products including emerging and flavored tobacco products. TCP provides information and technical assistance to public housing entities and managers of multi unit housing properties that are ready to adopt smoke-free policies. TCP partners with the RIDEM to support a ban on smoking on beaches and continues to share information with stakeholders on the dangers of smoking in outdoor spaces. TCP provides data on smoke-free outdoor dining to stakeholders. These activities help contribute to the social norms change that shapes the social and emotional environment in the state.

/2014/ Every two years, HEALTH conducts the RIYRBS. YRBS collects data from a statewide sample of 9-12th graders on past 30-day tobacco use, which is the measure for "current smoker". DCFHE participated in the development of the RIDE's Surveyworks tool, a school-based survey that collects data on issues related to youth wellness & risk behaviors. The same 30-day tobacco use measure found on the YRBS is used by Surveyworks. Surveyworks provides community-level data on past 30-day use of tobacco for 9th and 10Th graders. In summary, Rhode Island collects data on 9-12Th grader's use of tobacco in the past 30 days via both the YRBS, for a statewide prevalence rate of Surveyworks, for a school-level prevalence rate //2014//.

c. Plan for the Coming Year

/2014/ In May 2012 the TCP applied for an FDA media and health communications grant. No award has been made to date, but the TCP hopes that with the award of such a funding opportunity we will be able to continue to influence youth with high-quality media campaigns, including cutting edge use of social media, aimed at the continued de-normalization of smoking and other tobacco use. The TCP will engage in strategic planning and sustainability planning activities to determine its new five year plan to commence in April of 2014. The TCP envisions continuing to implement CDC best and promising practices in tobacco control. The level of resources and the outcome of strategic planning will set the course for our work in the coming year //2014//.

State Performance Measure 3: *Percent of insured adolescents who receive an annual preventive care visit.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				70	64
Annual Indicator	62.1	61.2	64.6	63.5	62.5
Numerator				60593	56499
Denominator				95491	90424
Data Source	Combined health plan data	Combined health plan data	Combined health plan data	Combined health plan data	Combined health plan data
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	67	67	70	70	70

Notes - 2012
Data for 2012 is the aggregate percent of adolescents enrolled in Medicaid and private health plans who received a preventive care visit. Data was received from Blue Cross/Blue Shield, Neighborhood Health Plan, CIGNA and United Healthcare.

Notes - 2011
Data for 2011 is the aggregate percent of adolescents enrolled in Medicaid and private health plans who received a preventive care visit. Data was received from Blue Cross/Blue Shield, Neighborhood Health Plan, CIGNA and United Healthcare.

Notes - 2010
This is a combined percentage from RI's three health plans that include both private and Medicaid insured adolescents. Numerators and denominators were provided by two of the three plans.

a. Last Year's Accomplishments

Rhode Island has a low rate of uninsured children, including adolescents. /2013/ In 2011, the aggregate percent of adolescents enrolled in Medicaid and private health plans who received a preventive care visit was 63.5%, a small decrease from 2010. Even though only 6.3% of Rhode Island's children under age 18 were uninsured during the period 2008 - 2010, approximately 40% of adolescents did not receive a well child visit in the previous year. There was no difference between private and public health insurance plans in terms of adolescent well care visits. The HEDIS national benchmark measure for adolescent well care visits is under 60%, which may explain why the health care utilization for adolescent well care is not better. Health insurance can provide access to care yet it does not capture provider characteristics (e.g. adolescent friendly, wellness promotion/risk reduction verses traditional visit); health plan incentives (e.g. do enrolled members use the services), youth and parent engagement strategies (support for visit and how they align with adolescent developmental needs) as well as policies (such as required for high school, more rigorous HEDIS measure) to increase the number of adolescents receiving well child visits need to be considered to develop supportive systems of care for adolescents.

The DCFHE worked with external stakeholders to identify potential barriers and support to adolescents receiving care and best approaches to enable adolescents to access preventive care. Over 30 key informant interviews were held with topics including background health objectives for adolescents, health care delivery settings, barriers to care, needs of specific subpopulations of adolescents focused on disparities, provider training, practice guidelines/content of adolescent care, privacy/confidentiality, health insurance for preventive health services, and measuring quality/effectiveness of care. Focus groups with adolescents are planned. The DCFHE also unveiled the Rhode Island Alliance for Teen Pregnancy Prevention statewide strategic plan.

The DCFHE supported Woonsocket CATCH grant partners to establish on-site health services at Woonsocket High School through Thundermist Health Center. Technical assistance included adolescent medical home development and family planning //2013//.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Worked with external stakeholders to identify potential barriers and support to adolescents receiving care and best approaches to enable adolescents to access preventive care.			X	
2. Unveiled the Rhode Island Alliance for Teen Pregnany Prevention statewide strategic plan.				X
3. Supported Woonsocket CATCH grant partners to establish on site health services at Woonsocket High School through Thundermist Community Health Center.	X			
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

DCFHE convened an Adolescent Transition working Group of the Successful Start Steering Committee to expand the early childhood systems work to children and adolescents.

DCFHE continued to support two school-based health centers in West Warwick and Providence. The West Warwick site is supported with state legislative community support grants and the Providence center is supported through state funds, grants, and reimbursement for services.

/2013/ The DCFHE produced an Adolescent Access to Health Care Report including literature review, quantitative and qualitative data to inform recommendations to improve access to care among adolescents in RI.

The DCFHE continues to support Woonsocket CATCH grant partners to establish on-site health services at Woonsocket High School through Thundermist Health Center. Technical assistance included adolescent medical home development and family planning //2013//.

c. Plan for the Coming Year

The DCFHE will develop opportunities to work with communities on adolescent health issues, developing assets and reducing health risks. The DCFHE will seek new opportunities to engage youth in action research in a variety of health risk areas.

/2013/ The DCFHE will continue to work with state and community level groups on issues related to access including the Rhode Island Alliance for Teen Pregnancy Prevention, Preconception Health Strategic Plan, the Rhode Island Task Force on Premature Births, and the Covering KIDS RI Workgroup.

The DCFHE will design and implement an adolescent health summit to inform near term strategies to support adolescent health statewide. A broad-based group of adolescent health partners will plan, implement, and evaluate these efforts.

The DCFHE will continue to work on medical homes for teens with Woonsocket CATCH grant partners as well as the Washington County Coalition for Children CATCH project in Westerly which focuses on teen pregnancy, delayed prenatal care, and food insecurity //2013//.

State Performance Measure 4: *Percent of high school students with special needs who report feeling sad or hopeless*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(ii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				41.8	40.7
Annual Indicator	40.8	42.1	42.1	38.8	38.8
Numerator	3901	3857	3889	3908	3908
Denominator	9556	9166	9242	10071	10071
Data Source	YRBS 2007	YRBS 2009	YRBS Estimate	YRBS 2011	YRBS 2011
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	38.6	38.4	37.8	37.5	36.7

Notes - 2012
Data are an estimate only. The Youth Risk Behavior Survey [YRBS] is conducted every other year. Next survey will be conducted in fall of 2013.

Notes - 2011
Data source: Youth Risk Behavior Survey [YRBS]. The YRBS is conducted every other year. Data for 2011 reflects a decline in the percent of high school students with special needs who report feeling sad or hopeless. Percent in 2009 was 42.1% compared to 38.8% in 2011.

Notes - 2010
Data are an estimate only. The Youth Risk Behavior Survey [YRBS] is conducted every other year. Next survey will be conducted in fall of 2011.

a. Last Year's Accomplishments
/2014/ Youth with disabilities are more likely to report feelings of hopelessness and to consider and attempt suicide than their non-disabled peers. 2011 YRBS data indicate 41.7% of youth with disabilities report feeing sad or hopeless as opposed to only 17% of their non-disabled peers //2014//.

OSHCN, is actively engaged in a positive youth development program for youth with special needs / disabilities and their families. Through a positive youth development approach, students explore, develop, and showcase concepts of leadership to increase positive outcomes of achieving successful transition to adulthood, developing deeper connections to their communities and peers, and feel more in control of their lives.

OSHCN partners with community organizations and state agency leaders in highlighting the risk behaviors of students with special needs and systematically addresses them through increasing the following: well-integrated academic intervention; positive social and recreational activities; programs that support self-determination and student leadership; interventions that address behavioral health care needs; effective transition planning from school to adulthood including academic, vocational and healthcare; connections to appropriate adult role models; and support for community based experiences such as employment.

/2013/ Since May of 2009, OSHCN and its partners have sponsored a statewide initiative for youth with disabilities or special health care needs entitled Dare to Dream (D2D). Held on a college campus, the conference day's event includes a young adult motivational speaker with a disability sharing their life experience //2013//. As students hear from a peer who has succeeded, their expectations and aspirations are raised. They learn to put their disability in perspective and not let it define who they are. Most important of all, from a transition perspective, students begin to see the future as a set of options that they control, not a predetermined set of events.

Preparing for the conference is the culmination of a year planning for the state and an exercise in teamwork for the participating school district students. Since students with disabilities have few chances for leadership in traditional high schools, a major outcome of the conference is that students in special education are provided with the opportunity to be leaders, self advocates, and teachers to their peers. Students are encouraged to bring information gained from their conference experience back to their own schools. As a result, many student participants have made presentations to teachers, parents, younger students, and school boards of education. /2013/ Since 2009, the annual D2D conference has touched the lives of thousands of students //2013//. Teachers, counselors, transition coordinators, and youth leaders continue to support the opportunity the conference provides for students to spend time reflecting on who they are, where they are going in the future, and how they might get there.

/2013/ In 2010, D2D was expanded to include ongoing youth leadership development/membership opportunities in each community and across a variety of interests. The

RI Transition Council produced a Directory of Youth Leadership Development Opportunities to provide teachers, guidance counselors, transition stakeholders, youth workers, community organizers, youth and families with local and national resources to build youth leadership. The Directory was presented to D2D supporters at a luncheon in the summer of 2010 //2013//.

/2014/ The 2013 D2D Student Conference was held on May 22nd at URI with a registration of over 500 youth and participation from 31 of the 35 school districts. The 2012 conference revealed the Dream Team as the Master of Ceremonies and lead conference organizers //2014//. /2013/ The Dream Team is comprised of 12 young adults with special needs from a variety of districts throughout the state who advise OCHCN on positive youth development //2013//.

/2014/ Throughout 2013, the OSHCN trained 15 youth as Health Coaches and presenters of the evidence-based Healthy Lifestyles curriculum. To date, these trainers offered 16-hour Healthy Lifestyles courses to over 45 students and young adults. The OSNCN established a Youth Advisory Committee which has held 10 meetings, issued advisory letters and developed the agenda for the 2013 Dare to Dream Student Conference //2014//.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implemented a positve youth development program (Dare to Dream) for youth with special needs/disabilities and their families.				X
2. Partnered with community organizations and state leaders in highlighting the risk behaviors of students with special needs and addressed them through several strategies.				X
3. Sponsored a statewide Dare to Dream conference.		X		
4. Worked with a RI Transition Council to produce a Directory of Youth Leadership Opportunities as a part of Dare to Dream.		X		
5. Held a luncheon for Dare to Dream supporters.		X		
6. Rolled out a Dare to Dream Start-Up Kit.		X		
7. Created a Dream Team comprised of 12 adults with special needs who advise the OSHC on positve youth development.		X		
8.				
9.				
10.				

b. Current Activities

/2013/ OSHCN is actively engaged in a positive youth development program for youth with special needs / disabilities and their families. Current activities include an expanded offering of Dare to Dream youth leadership opportunities on a regional basis throughout the state and TA to community and school youth programs on inclusion of youth with special needs/disabilities. OSHCN engages in youth empowerment learning through hosting parent and professional workshops, conferences, tailoring outreach efforts, and partnering with the state's regional transition centers in designing materials //2013//.

/2014/ OSHCN and RIPIN will again partner with the Department of Labor & Training Youth Works Summer Training Program for 10 youth to participate in an intensive job training program as Youth Health Coaches. Youth will be trained on the evidence-based Healthy Lifestyles for People with Disabilities curriculum. Youth Health Coaches will be deployed to schools and communities in the fall of 2013 //2014//.

c. Plan for the Coming Year
The OSHCN will continue to engage in a positive youth development program for youth with special needs / disabilities and their families. ***/2014/ The OSHCN will continue to participate in the RI Transition Council, the State Special Education Advisory Committee, and the Family Care and Community Partnership boards (system of care for SED children and youth, child welfare) in setting statewide policy for youth with special needs in transition //2014//.***/2013/ These collective bodies advise local special education programs //2013//.

Through a positive youth development approach, students explore, develop, and showcase concepts of leadership to increase positive outcomes of achieving successful transition to adulthood, developing deeper connections to their communities and peers, and feel more in control of their lives.

The OSHCN partners with community organizations and state agency leaders will continue to highlight the risk behaviors of students with special needs and systematically address the needs through increasing the following: well-integrated academic intervention; positive social and recreational activities; programs that support self-determination and student leadership; interventions that address behavioral health care needs; effective transition planning from school to adulthood including academic, vocational and healthcare; connections to appropriate adult role models; and support for community based experiences such as employment.

The OSHCN will continue to expand the Dare to Dream Student Leadership Initiative for transition age students (14-21). /2013/ It will expand the Youth Health Coach Program as appropriate and will provide inclusion opportunities for youth with disabilities to be supported and empowered in their schools and communities //2013//.

State Performance Measure 5: *Percent of women with health insurance who had a preventive care visit in the past year.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				85.2	85.5
Annual Indicator	84.7	85.1	84.7	83.2	86.2
Numerator	341436	333206	334337	323469	334648
Denominator	403112	391642	394571	388784	388417
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	87.2	88	88	88	89

Notes - 2012
2012 Data are provisional.

Notes - 2011
Method for 2011 changed and the 2011 data reflect new baseline indicator. Data for 2011 are not to be compared to prior years.

Notes - 2010
Data are estimated.

a. Last Year's Accomplishments

/2013/ The Office of Women's Health (OWH) monitors annually, the percent of women who have had a preventive care visit in the last year /2013//. This figure has held steady, fluctuating insignificantly around 84% since 2006. To improve this indicator of access to and utilization of women's health, the OWH collaborates with a number of programs inside of and external to HEALTH. /2013/ The OWH participated on the Health Insurance Exchange Work Group of Rhode Island's Health Reform Commission //2013//.

The Women's Health Advisory Committee (WHAC), the advisory committee to the Director of Health, and OWH submitted feedback during the Title V community input process for the needs assessment and encouraged HEALTH to improve access to preventive care for women. In its capacity, the WHAC has discussed, issued recommendations, and taken action upon several topics that impact women's health and their health care experience- fecal incontinence, preconception care, breast cancer screening among senior women, exercise & health, healthy relationships among teen girls, newborn screening, and state legislation that impacts the health of women and girls.

Similarly, the Primary Care Providers Advisory Committee (PCPAC) to the Director of Health, the body that provides recommendations to improve primary care capacity, delivery, and quality for women, children and men issued recommendations to the Director of Health and the Health Insurance Commissioner related to commercial insurers' revenue investments in primary care infrastructure, provider recruitment, and the Patient Centered Medical Home. These recommendations, some of which are being implemented, will improve the quality of preventive and primary care services for women across the state.

In addition, the Health Disparities and Access to Care Team, which includes the OWH, helped establish and fund the Community Health Worker Association of RI. This benefits women's preventive health because community health workers (CHWs) have aggressively outreached at community based settings to inform residents of health care options for insured and uninsured persons and have signed residents up for Medicaid. The primary beneficiaries of CHW services in RI are women and children.

/2014/ The OWH participated in the Preconception Planning Collaborative, Preconception Health Strategic Plan, and Preconception Health Summit. These events and materials work to improve access to comprehensive, high quality primary care services for women and girls and address intentional family planning practices //2014//.

The Women's Health Council of RI is a unifying organization of providers, payers, policy makers, and community members dedicated to moving women's health care in RI from the traditional focus on breast and obstetrics/gynecological health towards an improved system of comprehensive, integrated care. The WHC-RI has developed an expanded definition of standards for women's health care, "Comprehensive and coordinated research, education, clinical care and policy/advocacy that improve the social, physical and mental health of women across their lifespan."

/2013/ The Rural Health Program (RHP) issued a Systems Building RFP to improve and expand primary care in rural/non-metro areas of the state //2013//. ***/2014/ Integrated funding from Primary Care, Rural Health, and Title V is being used to fund four Rural Health Systems Building Grants that began in January 2013, as well as a separate contract to evaluate the impact of the systems building grants //2014//.*** /2013/ This work will include developing methods and tools that could be utilized by other community partnership initiatives of HEALTH //2013//.

/2014/ The Office of Primary Care and Rural Health administers the State loan Repayment Program Grant that is used to attract additional primary care providers to come to or remain in practice in health professional shortage areas//2014//. /2013/ In addition, OPC reviewed all National Health Service Corps (NHSC) applications received and recommended

many for approval. The OPC also provided TA to primary care, dental, and behavioral health providers that were seeking to become approved sites for NHSC clinicians, thereby expanding access to health care in health professional shortage areas //2013//.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supported the DCFHE's Office of Women's Health (OWH) to monitor this indicator.			X	
2. Supported the OWH's Women's Health Advisory Commitee (WHAC) to provide recommendations for improving the quality and access to health care for women.				X
3. Supported HEALTH's Primary Care Providers Advisory Committee (PCPAC) to make recommendations for improving women's access to health care.				X
4. Supported the Community Health Worker Association of Rhode Island to provide outreach to women on the community level and enroll them in Medicaid.		X		
5. Worked with the Women's Health Council (WHC) to develop an expanded definition of standards for women's health care.				X
6. Supported the DCFHE's Rural Health Program to improve and expand primary care in non-urban communities.				X
7. Supported the self-management chronic disease education program called A Place to Be Healthy at Clinica Esperanza Hope Clinic in Providence.		X		
8. Reviewed National Health Service Corps (NHSC) applications and recommnended many for approval.			X	
9. Provided TA to primary care, dental, and behavioral health care providers seeking to become approved NHSC sites.		X		
10. Participated on the Health Insurance Exchange Work Group of RI's Health Reform Commission.				X

b. Current Activities

/2013/OWH participates on the Health Insurance Exchange Work Group of Rhode Island's Health Reform Commission. This is the body that recommends minimum benefits to be covered by the RI Health Insurance Exchange. This has tremendous potential to improve the percent of women who have had a preventive care visit in the last year //2013//. ***/2014/ RI is preparing for the implementation of the Affordable Health Care Act, which will require coverage of well woman visits, mammograms, birth control, and smoking cessation services at no cost to women. OWH collaborates with the Preconception Health Program in implementing the strategic plan for women and girls //2014//.***

/2013/ In an effort to provide dental care for adult refugees, including women, the DCFHE's Oral Health Program worked with St. Joseph Hospital, which agreed to see adult refugees in their dental clinic on Saturdays. DCFHE's Refugee Health Program is working to increase the percentage of refugees for whom a health screening form is submitted within 30 days of the refugee's arrival.

The OWH continues to staff the Women's Health Advisory Committee to the Director of Health //2013//.

/2014/ The DCFHE's CHEW project includes a culturally appropriate self-management

chronic disease education program called "A Place to Be Healthy" through the Clinica Esperanza Hope Clinic in Providence //2014//.

c. Plan for the Coming Year

/2014/ The Office of Primary Care and Rural Health will establish the State Loan Repayment Program and Advisory Board to attract additional primary care providers to come to or remain in practice in health professional shortage areas //2014//.

/2013/ The Office of Primary Care will continue to collaborate with key partners, other State agencies, and State recruitment efforts to incorporate National Health Service Corps resources (i.e., Scholars, Loan Repayors, and Ready Responders) in the State's strategy to increase the number of health professionals serving in health professional shortage areas. Further, the Office of Primary Care will engage in activities that successfully recruit and retain clinical staff to work in safety net settings in RI, with a particular emphasis on community health center sites.

The Office of Women's Health will continue to serve on the Women's Health Council and will co-host the third annual Women's Health Quality Conference, which will focus on the social and economic determinants of women's health.

The OWH will continue to participate on relevant Health Reform Commission and Preconception Planning work groups in order to increase women's access to and utilization of preventive services.

The OWH will continue to participate on the Health Insurance Exchange Work Group of Rhode Island's Health Reform Commission. It will also continue to participate on the Preconception Care Health Collaborative.

St. Joseph Hospital will continue to see adult refugees in their dental clinic on Saturdays. The DCFHE's Refugee Health Program will continue to work to increase the increase the percentage of refugees for whom a health screening form is submitted within 30 days of the refugee's arrival.

The Office of Women's Health will continue to serve on the Women's Health Council and will co-host the third annual Women's Health Quality Conference, which will focus on the social and economic determinants of women's health //2013//.

/2014/ The DCFHE's CHEW project will continue to include a culturally appropriate self-management chronic disease education program called "A Place to Be Healthy" through the Clinica Esperanza Hope Clinic in Providence //2014//.

State Performance Measure 6: *Percent of pregnant women determined at risk for poor outcomes, residing in selected communities, who receive a home visit during the prenatal period.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				38.2	40
Annual Indicator			7.1	24.1	10.3
Numerator			25	83	120
Denominator			354	345	1166
Data Source			Kidsnet Database	Kidsnet Database& Effors to Outcomes	Kidsnet Database& Effors to Outcomes

Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	15	21	22	24	26

Notes - 2012
The decline in this SPM is due to the increase of women and communties selected for the measure.

Starting with 2012, this SPM captures women less than 25 years old (instead of lt 21), living in the 4 core cities or in West Warwick or Newport. These women are considered at highest risk if they do not have a high school education and are on medicaid.

This state performance measure is hoping to show improved outcomes if prenatal services are provided to these women.

Notes - 2011
Provisional data. For 2012 two additional communities will be added to the numerator [Newport and West Warwick].

Notes - 2010
Women are considered at highest risk if they are aged le 20 and do not have a high school education and are on medicaid. The selected communites include 4 of the core cities.

This new state performance measure is hoping to show improved outcomes if prenatal services are provided to these women.

a. Last Year's Accomplishments
/2013/ First Connections provided home visiting services to pregnant women on a limited basis //2013//. ***/2014/ Rhode Island has high rates of premature births, low birth weight, infant mortality, and child maltreatment in the core cities of Central Falls, Pawtucket, Providence, and Woonsocket, as well as Newport and West Warwick. Families in these communities face multiple risk factors and have been identified as those most able to benefit from intensive, evidence based home visiting programs that will improve coordination of services. Rhode Island currently has limited capacity to provide evidence-based prenatal home visiting. Expanding home visiting programs will help to improve and strengthen programs and activities carried out under Title V and improve coordination of services to improve outcomes for families at risk. Through the MIECHV Program, HEALTH has implemented Healthy Families America, Nurse Family Partnership, and parents as Teachers to support pregnant women and families. Still, Rhode Island has limited capacity to provide evidence-based prenatal home visiting services. MIECHV infrastructure includes a Home Visiting Leadership Council, Local Implementation Teams, Community Coalitions, and a Home Visiting Network //2014//.***

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Supported First Connections to provide home visiting services to pregnant women on a limited basis.	X			
2. Was awarded HRSA MCHB Maternal, Infant, and Early Childhood Home Visiting (MIECHV) funds to create capacity for evidence-based prenatal home visiting services in communities at risk for poor outcomes.	X			

3. Created an infrastructure to support statewide home visiting services for pregnant women in communities at risk for poor outcomes through the Home Visiting Leadership Council, Local Implementation Teams, and a Home Visiting Network.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2014/ DCFHE continues to support First Connections. In addition, the DCFHE was awarded MIECHV funding to implement three evidence-based home visiting programs for pregnant women and families with children up to age three in six urban core communities. The three evidence-based models being implemented are Nurse Family Partnership, Healthy Families America, and Parents as Teachers. Significantly, the MIECHV funding allows the DCFHE to expand home visiting services to pregnant women. MIECHV infrastructure includes a Home Visiting Leadership Council, Local Implementation Teams, Community Coalitions, and a Home Visiting Network //2014//.

c. Plan for the Coming Year

/2014/ DCFHE will continue to support First Connections and the three evidence-based MIECHV programs in FY2014. It will also continue to support MIECHV infrastructure including a Home Visiting Leadership Council, Local Implementation Teams, Community Coalitions, and a Home Visiting Network //2014//. /2013/ The DCFHE will work with state and local partners to create an integrated prenatal referral system for home visiting services //2013//.

State Performance Measure 7: *Percent of parents with children in early childhood that enroll in evidence based parenting education\support programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective				8.5	4.5
Annual Indicator			4.2	4.1	4.8
Numerator			1434	1375	1530
Denominator			34040	33440	31830
Data Source			Various	Various	Various
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	5.2	5.8	7.2	7.5	7.8

Notes - 2012

Data from 2010 - 2012 shows a slight increase in the number of parents enrolled in parenting/support programs.

Notes - 2011

The increase in parents enrolled in evidence based parent education programs was lower than expected. There were 2 main factors that contributed tho this. One of the programs [HIPPY] lost federal funding and the number of slots declined from 260 slots to 30. In addition, Rhode Island

Department of HEALTH has awarded contracts to community agencies to implement such programs but in 2011 these programs were not yet available.

a. Last Year's Accomplishments

/2013/ More evidence-based programs that demonstrate outcomes are needed to ensure that resources are allocated to programs that improve outcomes. During May 2011, HEALTH convened a meeting that highlighted evidence based programming and practices the improve child health outcomes. The efforts included: a training program for children, parents, and teachers that support the social-emotional competence of children at high risk, the Nurse Family Partnership program for home visiting to new families at high risk, and a youth development approach to teen pregnancy prevention. HEALTH submitted a grant to HRSA - Maternal, Infant and Early Childhood Home Visiting Program to expand that capacity within the state to provide evidence-based home visiting services, //2013// ***/2014/ which now include Healthy Families America and the additional Parents as Teachers slots. MIECHV infrastructure includes a Home Visiting Leadership Council, Local Implementation Teams, Community Coalitions, and a Home Visiting Network //2014//.*** /2013/ In addition, the DCFHE worked with the Successful Start Steering Committee to coordinate evidence-based parent education/support and support to parents //2013//.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Was awarded HRSA MCHB Maternal, Infant, and Early Childhood Home Visiting (MIECHV) funds to create capacity for evidence-based prenatal and early childhood home visiting services in core communities.	X			
2. Worked with the Successful Start Steering Committee to coordinate evidence-based parent education/support programs and support parents.				
3. Convened, with KIDSNET, a meeting to highlight evidence-based programs and practices that improve child health outcomes.				X
4. Created an infrastructure to support statewide home visiting services for pregnant women and families with young children through the Home Visiting Leadership Council, Local Implementation Teams, and a Home Visiting Network.		X		
5. Supported the evidence-based Incredible Years parenting groups in Providence and Pawtucket/Central Falls.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2014/ DCFHE was awarded MIECHV funding to implement 3 evidence-based home visiting programs for pregnant women and families with children up to age 3 in six urban communities //2014//. /2013/ The 3 evidence-based models being implemented are NFP, HFA, and PAT. Significantly, MIECHV allows DCFHE to expand home visiting services to pregnant women and families with young children in communities at risk for poor outcomes //2013//. ***/2014/ MIECHV infrastructure includes a Home Visiting Leadership Council, Local Implementation Teams, and a Home Visiting Network. At the Local Implementation Teams, HEALTH is working on coordinated referrals systems to ensure that young pregnant and parenting women and families are linked with evidence-based parenting education and support***

programs and other appropriate community resources //2014//.

/2013/ DCFHE continues to work with the Successful Start Steering Committee to coordinate evidence-based parent education/support and support to parents. DCFHE received Race to the Top Early Learning challenge funds to work with other state agencies to improve early learning and development opportunities for young children. The team will support 90 pediatric practices to implement standardized developmental screening and will also provide supports to PCPs to address the needs of families in their practice that arise as a result of the screening //2013//.

/2014/The DCFHE's CHEW project includes evidence--based Incredible Years parenting groups //2014//.

c. Plan for the Coming Year

/2013/ DCFHE will continue to support the three evidence-based MIECHV programs and the Race to the Top Early Learning Challenge activities in FY2013. It will continue to support MIECHV infrastructure including a Home Visiting Leadership Council, Local Implementation Teams, and a Home Visiting Network. It will also continue to work with the Successful Start Steering Committee to coordinate evidence-based parent education/support and support to parents //2013//.

/2014/The DCFHE's Title V funded CHEW project includes evidence--based Incredible Years parenting groups in Providence and Pawtucket/Central Falls //2014//.

State Performance Measure 8: *Percent of RI adolescents who report food insecurity.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective				11	3.2
Annual Indicator				3.6	3.6
Numerator				1488	1488
Denominator				41291	41291
Data Source				YRBS	YRBS
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	3.3	3.1	3.2	3.5	3.4

Notes - 2012

Data are estimated. The YRBS is conducted every other year and the food insecurity questions were collected during the 2010/2011 school year. The YRBS will next be conducted during the 2013 school year.

Notes - 2011

Data from the YRBS. The YRBS is conducted every other year and the food insecurity questions were collected during the 2010/2011 school year.

Notes - 2010

SPM #8: Percent of Rhode Island adolescents who report food insecurity.

Data not available and no estimate is available. Question was added to YRBS survey for the 2011school year. Data on this question should be available by June 2012.

a. Last Year's Accomplishments

/2014/ The Initiative for a Healthy Weight reviewed municipal comprehensive plans for alignment with the Healthy Communities Plan (HCP) and provided municipalities with suggestions for improvement. The HCP outlines goals, objectives, policies, and strategies that municipalities should incorporate into the comprehensive plans to ensure access to healthy foods for residents. A newly formed Inter-Agency Food and Nutrition Policy Advisory Council, consisting of HEALTH, DEM, ad DOA was formed through RI General Law 21-36. The Council is charged with identifying challenges and solutions to a healthy and sustainable food system in RI //2014//.

/2013/ WIC provided pregnant teens, breastfeeding teen mothers, and post-partum teen mothers with access to healthy foods through WIC and WIC Farmers Markets. WIC implemented a new WIC food package with increased fruits and vegetables, more culturally appropriate foods, and lower fat foods //2013//.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Initiated, through the DCFHE's Initative for a Healthy Weight (IHW), development of a statewide Food Council.				X
2. Partnered with the Environmental Justice League of RI to implement the Providence Healthy Corner Store Initiative.		X		
3. Received a CPPW grant to identify healthy community indicators, including those related to food access.			X	
4. Worked with the Division of Planning and the Department of Environmental Management to address food access recommendations for local communities to include as part of their local comprehensive plans.				X
5. Supported WIC to provide pregnant teens, breastfeeding teen mothers, and post-partum teen mothers with access to healthy foods through WIC and WIC Farmers Markets.	X			
6. Implemented a new WIC food package with increased fruits and vegetables, more culturally appropriate foods, and lower fat foods.	X			
7. Supported Woonsocket CATCH grant partners to establish on site health services at Woonsocket High School through Thundermist Community Health Center.	X			
8. Supported the Lots of Hope and Sankofa programs to increase access to healthy foods and reduce disparities in Providence neighborhoods				X
9.				
10.				

b. Current Activities

/2014/ IHW reviews comprehensive plans for alignment with the Healthy Communities Plan and provides feedback and support to municipalities to strengthen their comprehensive plans around food access. IHW is currently funding four projects that focus on access to healthy foods in Providence. IHW provides technical assistance and training to funded and non-funded partners on polices and practices to increase access to healthy foods. IHW continues to staff the Inter-Agency Food and nutrition Advisory Council //2014//.

/2013/ WIC provides pregnant teens, breastfeeding teen mothers, and post-partum teen mothers with access to healthy foods through WIC and WIC Farmers Markets. WIC continues to offer a new WIC food package with increased fruits and vegetables, more culturally appropriate foods,

and lower fat foods //2013//.

/2014/The DCFHE's Title V-funded CHEW project includes the Lots of Hope Program to turn unused city property into urban farms and the Sankofa Program to reduce diet-related disparities and improve eating behaviors of West End residents though a neighborhood intervention //2014//.

c. Plan for the Coming Year

/2014/ The IHW will continue to review municipal comprehensive plans and provide feedback, IHW will continue to staff the Council. IWH will continue to provide funding, training, and technical assistance to communities working to improve access to healthy food. //2014//.

/2013/ WIC will continue to provide pregnant teens, breastfeeding teen mothers, and post-partum teen mothers with access to healthy foods through WIC and WIC Farmers Markets. WIC will continue to offer a new WIC food package with increased fruits and vegetables, more culturally appropriate foods, and lower fat foods //2013//.

/2014/The DCFHE's Title V-funded CHEW project will continue to include the Lots of Hope Program to turn unused city property into urban farms and the Sankofa Program to reduce diet-related disparities and improve eating behaviors of West End residents though a neighborhood intervention //2014//.

State Performance Measure 9: *Percent of Rhode Island high school students who earn a high school diploma or diploma equivalent in four years for those that reside in the core cities.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				65.2	67
Annual Indicator		63.5	64.7	66.7	65.6
Numerator		2532	2527	2577	2229
Denominator		3990	3908	3862	3396
Data Source		Dept of Education	Dept of Education	Dept of Education	Dept of Education
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	66.1	66.2	66.2	66.7	66.7

Notes - 2012
Data from the Rhode Island Department of Education Infoworks and reflects the 4 year graduation rate.
Starting with 2012, data reflects only four core cities: Central Falls, Pawtucket, Providence and Woonsocket.

Notes - 2011

Data from the Rhode Island Department of Education Infoworks and reflects the 4 year graduation rate.
Data for 2009 - 2011 reported graduation rate for six core cities.

Notes - 2010
Data from the Rhode Island Department of Education Infoworks and reflects the 4 year graduation rate.

a. Last Year's Accomplishments
/2013/ According to the RI Department of Education, the four year graduation rate in Rhode Island's six core cities is 66.7% //2013//. Student achievement and graduation rates can be improved by using data to identify at-risk students during elementary and middle school. By the first quarter of the ninth grade or earlier, course failure patterns, poor behavior and attendance problems can be used to identify high risk students who are "off track" for graduation. Early warning systems that lead to the provision of personalized and timely academic and social support can help students get "on track" for graduation.

The United States Department of Health and Human Services Healthy People 2020 objectives for the nation include high graduation rate along with literacy and numeracy indicators of achievement for school aged children This inclusion underscores the interrelationship between positive health and education outcomes. Health research studies have shown that accountability for education outcomes has increased within an environment of complex social problems. Schools need support for building a broader context that includes ways for schools to have a positive influence on factors not always directly in their control and beyond traditional education approaches.

Data from the YRBS indicated that youth who reported having a disability, gay lesbian bisexual or unsure, or poor academic performance were all at higher risk for many of the health risk behaviors. Public health agencies can play a primary role in ensuring that students graduate from school by building systems approaches to address health concerns. Graduation from high school is a strong predictor of positive health outcomes in adulthood. The new Race to the Top funding stresses early childhood collaboration and is a model to build on for older youth.

DCFCHE and KIDSNET works with the Full Service Community School (FSCS) in Providence to connect families with chronically absent children to health services.

2013/ DCFHE received USDHHS Personal Responsibility Education Program (PREP) funds to implement evidence-based teen pregnancy prevention curriculum. DCFHE selected Wyman Center's Teen Outreach Program, a youth development program with demonstrated results in preventing teen pregnancy and supporting positive academic and health behaviors. DCFHE designed two competitive processes to identify local implementation partners and 1 statewide professional development partner.

DCFHE hosted the unveiling of the RI Alliance for Teen Pregnancy Prevention statewide strategic plan.

DCFHE collaborates with RI Kids Count on an issue brief titled: Disparities in children's Health, which makes the connection between disparities in education outcomes and health disparities among other issues.

The DCFHE continued to support Woonsocket CATCH grant partners to establish on-site health services at Woonsocket High School through Thundermist Community Health Center. The DCFHE continued to provide TA on adolescent medical home development and family planning //2013//.

/2014/ DCFHE worked with community partners to develop a Preconception Health

Strategic Plan including strategies to reduce teen pregnancy. MIECHV programs worked to ensure that pregnant women and young mothers that enroll in a program work to increase their economic self-sufficiency, which may include attaining a high school diploma or GED //2014//.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Worked with the Full Service Community Schools initiative in Providence to connect families with chronically absent children to health services as a way to improve school attendance.		X		
2. Used USDHHS Personal Responsibility Education Program (PREP) funds to implement evidence-based teen pregnancy prevention curriculum (Teen Outreach Program).	X			
3. Hosted the unveiling of the RI Alliance for Teen Pregnancy Prevention statewide strategic plan.				X
4. Collaborated with KIDSCOUNT on an Issue Brief titled Disparities in Children's Health, which makes the connection between disparities in education outcomes and health disparities.			X	
5. Suported the Healthier Olneyville and We Can CHEW projects in Providence neighborhoods.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

DCFHE continued to implement PREP for evidence-based youth development approach to teen pregnancy prevention.

/2013/ DCFHE produced an Adolescent Access to Care Report including literature review, quantitative and qualitative data to inform recommendations to improve access to care among adolescents in RI //2013//.

DCFHE participates on the FSCS Alliance including the RIDE and the state's 10 COZs. A grant was received from the RI Foundation to support work to develop capacity for full service community schools.

DCFHE continued to partner with RIDE on capacity building to support Thrive, RI's coordinated school health effort.

/2014/DCFHE implemented an adolescent health summit. A group of partners will plan, implement, and evaluate these efforts//2014//.

/2013/ DCFHE continues to work on teen medical homes with Woonsocket CATCH partners to establish on-site health services at Woonsocket High School through Thundermist Health Center. DCFHE continues to provide TA on medical home development and family planning. DCFHE also continues to support the Washington County Coalition for Children's CATCH project in Westerly that focuses on teen pregnancy, delayed prenatal care, and food insecurity //2013//.

/2014/ DCFHE and MOD hosted a Preconception Health Summit to provide strategies to

integrate preconception health into policy, programs, and practice.

The DCFHE's CHEW project includes initiatives to transform property into affordable housing and create open spaces, //2014//.

c. Plan for the Coming Year
The DCFHE will develop opportunities to work with communities on adolescent health issues, developing assets and reducing health risks. The DCFHE will seek new opportunities to engage youth in action research in a variety of health risk areas.

The DCFHE will continue to track births to teens and examine trends by demographic factors.

/2013/ DCFHE will continue to participate on the Full Service Community Schools Alliance Board //2013//.

DCFHE will explore opportunities to build partnerships with RIDE to support the connections between education and health outcomes at the State and local level.

/2014/ DCFHE will provide training and technical assistance in the Teen Outreach Program to 9 community partners to enable the implementation of this evidence-based program.

DCFHE will begin facilitation of the implementation of recommendations from the adolescent health summit that informed near term strategies to support adolescent health statewide //2014//. /2013/ A broad-based group of adolescent health partners will plan, implement, and evaluate these efforts.

The DCFHE will continue to work on teen medical homes with Woonsocket CATCH grant partners as well as the Washington County Coalition for Children CATCH project in Westerly that focuses on teen pregnancy, delayed prenatal care, and food insecurity //2013//.

/2014/ DCFHE will convene a core group of stakeholders and community partners, called the Preconception Health Collaborative, to begin implementing the state's Preconception Health Strategic Plan.

Healthy communities produce healthy residents. The DCFHE's CHEW project will continue to include initiatives to transform property into affordable housing; create and maintain parks and open spaces for recreation; encourage walking, riding, and use of RIPTA; and create a Neighborhood Policy Group in West Elmwood //2014//.

E. Health Status Indicators

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01A - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	8.0	8.0	7.7	7.5	8.0
Numerator	958	911	864	821	861
Denominator	12031	11421	11166	10940	10758
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the					

last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2012
Provisional data for 2012 show a slight increase from 7.5% in 2011 to 8.0%.

Notes - 2011
Birth data for 2011 show a slight decline from 7.7% in 2010 to 7.5%.

Notes - 2010
Rhode Island's percent of LBW infants declined from 8% to 7.7% in 2010.

Narrative:
/2014/ The percent of live births weighing less than 2,500 grams in RI has remianed about the same //2014//.
As part of a needs assessment process, the DCFHE, in partnership with the Center for Health Data and Analysis (CHDA), tracks, on an annual basis, the percent of live births weighing less than 2,500 and 1,500 grams and the percent of live singleton births weighing less than 2,500 and 1,500 grams. Data are drawn from the Office of Vital Records. This information is used to calculate low birth weight and very low birth weight. The Division looks at this data in conjunction with other maternal and child health indicators such as infant death, prematurity, and multiple births. The information is shared with community partners through the publication of our annual Title V application, 5 Year Needs Assessment and Annual Needs Assessment Summary. Data are also reported through our partnership with Rhode Island Kids Count, which publishes an annual Factbook on child wellbeing. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

In addition, birth weight and multiple birth codes are collected at birth in the integrated electronic birth certificate/developmental risk assessment system (VR2000) and stored in KIDSNET. A report is created in KIDSNET for the RI Department of Human Service's Early Intervention Program that reports the number of infants weighing less than 1500 grams by Early Intervention participation status. This report allows the Early Intervention Program to evaluate its success at engaging this target population in services.

The WIC Program also uses low birth weight data in the preparation of the WIC state plan, including ranking the relative need of communities across the State. This data is also shared at the local WIC level to ensure that those children who are enrolled in WIC and are low birth weight are offered or engaged in community-based services.

Successful Start uses this data to raise awareness of community health needs, facilitate and inform action to improvements performance, and develop recommendations about targeting resources to areas of highest need.

The First Connections Home Visiting program uses this data to identify children who will be offered home visits due to low birth weights and to follow up on children who were automatically referred to Early Intervention.

Integration of community health data into new venues, such as community based partnerships and city and town planning departments, are highly effective disseminators of such information and critical to the long term mission of public health intervention.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01B - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	6.2	6.0	6.0	5.8	6.0
Numerator	717	656	646	615	624
Denominator	11579	10956	10763	10568	10349
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2012
LBW data from 2008 to 2012 remained at about 6%.

Notes - 2011
Data for 2011 reflects a slight decline in the percent of LBW infants to 5.8%.

Notes - 2010
Data for 2010 shows the percent of LBW infants remains at 6%.

Narrative:
/2014/ The percent of live singleton births weighing less than 2,500 grams in RI has reamined about the same //2014//. As part of a needs assessment process, the DCFHE, in partnership with the Center for Health Data and Analysis (CHDA), tracks, on an annual basis, the percent of live births weighing less than 2,500 and 1,500 grams and the percent of live singleton births weighing less than 2,500 and 1,500 grams. Data are drawn from the Office of Vital Records. This information is used to calculate low birth weight and very low birth weight. The Division looks at this data in conjunction with other maternal and child health indicators such as infant death, prematurity, and multiple births. The information is shared with community partners through the publication of our annual Title V application, 5 Year Needs Assessment and Annual Needs Assessment Summary. Data are also reported through our partnership with Rhode Island Kids Count, which publishes an annual Factbook on child wellbeing. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

In addition, birth weight and multiple birth codes are collected at birth in the integrated electronic birth certificate/developmental risk assessment system (VR2000) and stored in KIDSNET. A report is created in KIDSNET for the RI Department of Human Service's Early Intervention Program that reports the number of infants weighing less than 1500 grams by Early Intervention participation status. This report allows the Early Intervention Program to evaluate its success at engaging this target population in services.

The WIC Program also uses low birth weight data in the preparation of the WIC state plan, including ranking the relative need of communities across the State. This data is also shared at

the local WIC level to ensure that those children who are enrolled in WIC and are low birth weight are offered or engaged in community-based services.

Successful Start uses this data to raise awareness of community health needs, facilitate and inform action to improvements performance, and develop recommendations about targeting resources to areas of highest need.

The First Connections Home Visiting program uses this data to identify children who will be offered home visits due to low birth weights and to follow up on children who were automatically referred to Early Intervention.

Integration of community health data into new venues, such as community based partnerships and city and town planning departments, are highly effective disseminators of such information and critical to the long term mission of public health intervention.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 02A - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	1.4	1.7	1.5	1.5	1.7
Numerator	172	195	170	165	185
Denominator	12031	11421	11166	10940	10758
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2012
Provisional data for 2012 reflects a slight increase in the percent of VLBW infants with 1.7% in 2012 compared to 1.5% in 2011.

Notes - 2011
Birth data for 2011 shows the percent of VLBW infants remained at 1.5% .

Notes - 2010
Data for 2010 reflects a slight decrease in the percent of VLBW infants with 1.5% in 2010 compared to 1.7% in 2009.

Narrative:
/2014/ The percent of live births weighing less than 1,500 grams in RI has remined about the same //2014//.
As part of a needs assessment process, the DCFHE, in partnership with the Center for Health Data and Analysis (CHDA), tracks, on an annual basis, the percent of live births weighing less than 2,500 and 1,500 grams and the percent of live singleton births weighing less than 2,500 and 1,500 grams. Data are drawn from the Office of Vital Records. This information is used to calculate low birth weight and very low birth weight. The Division looks at this data in conjunction with other maternal and child health indicators such as infant death, prematurity, and multiple births. The information is shared with community partners through the publication of our annual

Title V application, 5 Year Needs Assessment and Annual Needs Assessment Summary. Data are also reported through our partnership with Rhode Island Kids Count, which publishes an annual Factbook on child wellbeing. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

In addition, birth weight and multiple birth codes are collected at birth in the integrated electronic birth certificate/developmental risk assessment system (VR2000) and stored in KIDSNET. A report is created in KIDSNET for the RI Department of Human Service's Early Intervention Program that reports the number of infants weighing less than 1500 grams by Early Intervention participation status. This report allows the Early Intervention Program to evaluate its success at engaging this target population in services.

The WIC Program also uses low birth weight data in the preparation of the WIC state plan, including ranking the relative need of communities across the State. This data is also shared at the local WIC level to ensure that those children who are enrolled in WIC and are low birth weight are offered or engaged in community-based services.

Successful Start uses this data to raise awareness of community health needs, facilitate and inform action to improvements performance, and develop recommendations about targeting resources to areas of highest need.

The First Connections Home Visiting program uses this data to identify children who will be offered home visits due to low birth weights and to follow up on children who were automatically referred to Early Intervention.

Integration of community health data into new venues, such as community based partnerships and city and town planning departments, are highly effective disseminators of such information and critical to the long term mission of public health intervention.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 02B - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	1.0	1.2	1.2	1.2	1.2
Numerator	119	133	127	124	126
Denominator	11579	10956	10763	10568	10349
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2012
Rhode Island's percent of VLBW singleton births has remained about 1.0% - 1.2% since 2002.

Notes - 2011
Birth data for 2011 continues to reflect the percent of VLBW singleton births at 1.2%.

Notes - 2010
Data for 2010 continues to reflect the percent of VLBW singleton births at 1.2%.

Narrative:
/2014/ The percent of live singleton births weighing less than 1,500 grams in RI has remianed about the same /2014//. As part of a needs assessment process, the DCFHE, in partnership with the Center for Health Data and Analysis (CHDA), tracks, on an annual basis, the percent of live births weighing less than 2,500 and 1,500 grams and the percent of live singleton births weighing less than 2,500 and 1,500 grams. Data are drawn from the Office of Vital Records. This information is used to calculate low birth weight and very low birth weight. The Division looks at this data in conjunction with other maternal and child health indicators such as infant death, prematurity, and multiple births. The information is shared with community partners through the publication of our annual Title V application, 5 Year Needs Assessment and Annual Needs Assessment Summary. Data are also reported through our partnership with Rhode Island Kids Count, which publishes an annual Factbook on child wellbeing. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

In addition, birth weight and multiple birth codes are collected at birth in the integrated electronic birth certificate/developmental risk assessment system (VR2000) and stored in KIDSNET. A report is created in KIDSNET for the RI Department of Human Service's Early Intervention Program that reports the number of infants weighing less than 1500 grams by Early Intervention participation status. This report allows the Early Intervention Program to evaluate its success at engaging this target population in services.

The WIC Program also uses low birth weight data in the preparation of the WIC state plan, including ranking the relative need of communities across the State. This data is also shared at the local WIC level to ensure that those children who are enrolled in WIC and are low birth weight are offered or engaged in community-based services.

Successful Start uses this data to raise awareness of community health needs, facilitate and inform action to improvements performance, and develop recommendations about targeting resources to areas of highest need.

The First Connections Home Visiting program uses this data to identify children who will be offered home visits due to low birth weights and to follow up on children who were automatically referred to Early Intervention.

Integration of community health data into new venues, such as community based partnerships and city and town planning departments, are highly effective disseminators of such information and critical to the long term mission of public health intervention.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 03A - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	2.7		2.9		
Numerator	5		5		

Denominator	185916	170753	170753	170753	170753
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.				Yes	Yes
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2012
Data for 2012 is provisional. Currently there are only 1 cases of fatal unintentional injuries for children aged 00 - 14.
Denominator is from the 2010 Population Census.

Notes - 2011
Data for 2011 is provisional. Currently there are only 4 cases of fatal unintentional injuries for children aged 00 - 14.
Denominator is from the 2010 Population Census.

Notes - 2010
Data for 2010 is for children aged 00-14 and Denominator is from the 2010 Population Census.

Data for 2009 also reflects children aged 00-14.

Narrative:
The DCFHE is responsible for injuries in school age children and young adults. DCFHE identifies the injuries that are most prevalent, populations most in need, and strategies to ameliorate risks. The DCFHE's Safe RI Program works with the Department's Center for Health Data and Analysis to track, on an annual basis, deaths due to unintentional injuries and non-fatal injuries. Data is drawn from death records from Vital Statistics (for fatal injuries) and from Hospital Discharge Records (for non-fatal injuries). The information is shared with community partners through the publication of our annual Title V application, 5 Year Needs Assessment, and Annual Needs Assessment Summary. Data is also reported through our partnership with Rhode Island Kids Count, which publishes an annual Fact Book on child well being. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals. ***/2014/ First Connections and MIECHV home visitors are trained to identify sources of potential unintentional injuries for children receiving home visits and to provide the families of these children with childhood injury prevention education //2014//.***

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 03B - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator					
Numerator					
Denominator	185916	170753	170753	170753	170753

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Provisional	

Notes - 2012
Provisional data for 2012 reports 1 unintentional motor vechicle deaths.
Data reflect unintentional motor vechicle deaths to children aged 0 - 14.
Denominator from 2010 Population Census.

Notes - 2011
Provisional data for 2011 reports 1 unintentional motor vechicle deaths.
Data reflect unintentional motor vechicle deaths to children aged 0 - 14.
Denominator from 2010 Population Census.

Notes - 2010
Data for 2010 reports 2 unintentional motor vechicle deaths.
Data reflect unintentional motor vechicle deaths to children aged 0 - 14.
Denominator from 2010 Population Census.

Data for 2009 also reflects children aged 0-14.

Narrative:
HEALTH's Safe Rhode Island (SRI): SRI partnered with the Traffic Safety Coalition (TSC) and the Injury Prevention Center at RI Hospital to successfully advocate for the passage of legislation eliminating a major loophole in the state's drunk driving laws to cover individuals who refuse to submit to a breathalyzer test. The social host law was also strengthened to deter adults who knowingly provide alcohol to minors on their property. Rhode Island's Graduated Driver Licensing (GDL) law was improved to include a limit on cell phone use by youth less than 18 years while driving and a ban on texting while driving. Additionally, a voluntary two hour parent education class was integrated into the Community College of Rhode Island Driver Education Program curriculum. /2013/ The governor signed a primary seat belt law on June 30, 2011. This law allows police officers to ticket a driver solely on the basis that the driver is not wearing a seatbelt and makes enforcement of the law that covers children up to 18 years more likely //2013//.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 03C - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	11.5	11.7	8.0	3.1	6.2
Numerator	18	19	13	5	10
Denominator	157126	162213	162213	162213	162213
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and					

therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2012
Provisional data shows an increase from 3.1 per 100,000 in 2011 to 6.2 per 100,000 in 2012.

Denominator from the 2010 Population Census.

Notes - 2011
Data for 2011 is provisional. However, data shows a significant decline from 8 per 100,000 to 3.1 per 100,000 for unintentional injuries for youth aged 15-24 years old due to motor vehicle crashes.

Denominator from the 2010 Population Census.

Notes - 2010
Data reflects the rate of unintentional deaths involving a motor vechile for those aged 15 - 24 at 8 per 100,000 for 2010 compared to 11.7 for 2009.
Denominator from the 2010 Population Census.

Narrative:
/2014/ Motor vehicle crashes are a leading cause of death for youth ages 15-24 (CDC WISQUARS, 2006-2010). The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years in RI is going down //2014//.
The leading contributors to motor vehicle crash deaths are not wearing a seatbelt and drunk driving. HEALTH's Safe Rhode Island (SRI): SRI partnered with the Traffic Safety Coalition (TSC) and the Injury Prevention Center at RI Hospital to successfully advocate for the passage of legislation eliminating a major loophole in the state's drunk driving laws to cover individuals who refuse to submit to a breathalyzer test. The social host law was also strengthened to deter adults who knowingly provide alcohol to minors on their property. Rhode Island's Graduated Driver Licensing (GDL) law was improved to include a limit on cell phone use by youth less than 18 years while driving and a ban on texting while driving. Additionally, a voluntary two hour parent education class was integrated into the Community College of Rhode Island Driver Education Program curriculum. /2013/ The governor signed a primary seat belt law on June 30, 2011. This law allows police officers to ticket a driver solely on the basis that the driver is not wearing a seatbelt and makes enforcement of the law that covers children up to 18 years more likely //2013//.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 04A - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	146.3	159.3	165.2	161.1	125.9
Numerator	272	272	282	275	215
Denominator	185916	170753	170753	170753	170753
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and					

therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2012
Provisional 2012 data shows a decline in the rate of all nonfatal injuries among children aged 14 years and younger from 161.1 per 100,000 to 125.9 per 100,000. Data excludes newborns.

Starting with 2010, Rhode Island adopted the requirements listed in the 'State Injury Indicators Report - 2010 Data,' published by CDC.
The publication recommends that all diagnoses [dx 2- dx 25] should be counted.

Data source: Hospital Discharge Database [HDD].
Data reflects Rhode Island resident events that were treated in Rhode Island hospitals.

Denominator reflects children aged 0 -14 and is from the 2010 Census.

Notes - 2011
Provisional 2011 data shows a slight decline in the rate of all nonfatal injuries among children aged 14 years and younger from 165.2 per 100,000 to 161.1 per 100,000. Data excludes newborns.

Notes - 2010
Starting with 2010, Rhode Island adopted the requirements listed in the 'State Injury Indicators Report - 2010 Data,' published by CDC.
The publication recommends that all diagnoses [dx 2- dx 25] should be counted. Data excludes newborns.

Data source: Hospital Discharge Database [HDD].
Data reflects Rhode Island resident events that were treated in Rhode Island hospitals.

Starting with 2010, denominator reflects children aged 0 -14 and is from the 2010 Census.

Narrative:
/2014/ The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger in Rhode Island appears to be going down //2014//. The DCFHE is responsible for injuries in school age children and young adults. DCFHE identifies the injuries that are most prevalent, populations most in need, and strategies to ameliorate risks. The DCFHE's Safe RI - - Violence and Injury Prevention Program works with the Department's Center for Health Data and Analysis to track, on an annual basis, deaths due to unintentional injuries and non-fatal injuries. Data is drawn from death records from Vital Statistics (for fatal injuries) and from Hospital Discharge Records (for non-fatal injuries). The information is shared with community partners through the publication of our annual Title V application, 5 Year Needs Assessment, and Annual Needs Assessment Summary. Data is also reported through our partnership with Rhode Island Kids Count, which publishes an annual Fact Book on child well being. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals. ***/2014/ First Connections and MIECHC home visitors are trained to identify potential sources of injuries for young children who receive home visits and to provide the families of such children with injury prevention education //2014//.***

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 04B - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	8.6	8.2	12.9	18.2	9.4
Numerator	16	14	22	31	16
Denominator	185916	170753	170753	170753	170753
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2012
Provisional 2012 data shows a decline in the rate of all nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger. Data excludes newborns.

Starting with 2010, Rhode Island adopted the requirements listed in the 'State Injury Indicators Report - 2010 Data,' published by CDC.
The publication recommends that all diagnoses [dx 2- dx 25] should be counted.

Data source: Hospital Discharge Database [HDD].
Data reflects Rhode Island resident events that were treated in Rhode Island hospitals.

Denominator reflects children aged 0 -14 and is from the 2010 Census.

Notes - 2011
Provisional data for 2011 shows the rate of nonfatal injuries due to motor vehicle crashes increased to 18.2 per 100,000 for 2011 compared to 12.9 in 2010. Data does not include newborns.

Denominator for children aged 0-14 from the 2010 Census.

Notes - 2010
Starting with 2010, Rhode Island adopted the requirements listed in the 'State Injury Indicators Report - 2010 Data,' published by CDC.
The publication recommends that all diagnoses [dx 2- dx 25] should be counted. Data excludes newborns.

Data source: Hospital Discharge Database [HDD].
Data reflects Rhode Island resident events that were treated in Rhode Island hospitals.

Denominator reflects children aged 0 -14 and is from the 2010 Census.

Narrative:
/2014/ The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger in Rhode Island appears to be going up, however, the number of children in this category reamains very small //2014//. HEALTH's Safe Rhode Island (SRI) partnered with the Traffic Safety Coalition (TSC) and the Injury Prevention Center at

RI Hospital to successfully advocate for the passage of legislation eliminating a major loophole in the state's drunk driving laws to cover individuals who refuse to submit to a breathalyzer test. The social host law was also strengthened to deter adults who knowingly provide alcohol to minors on their property. Rhode Island's Graduated Driver Licensing (GDL) law was improved to include a limit on cell phone use by youth less than 18 years while driving and a ban on texting while driving. Additionally, a voluntary two hour parent education class was integrated into the Community College of Rhode Island Driver Education Program curriculum. /2013/ The governor signed a primary seat belt law on June 30, 2011. This law allows police officers to ticket a driver solely on the basis that the driver is not wearing a seatbelt and makes enforcement of the law that covers children up to 18 years more likely //2013//.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 04C - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	56.6	59.8	86.9	78.3	77.7
Numerator	89	97	141	127	126
Denominator	157126	162213	162213	162213	162213
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2012
The provisional rate of all nonfatal injuries due to motor vehicle crashes among children aged 15 - 24 years old remained about the same for 2011 and 2012.

Starting with 2010, Rhode Island adopted the requirements listed in the 'State Injury Indicators Report - 2010 Data,' published by CDC.
The publication recommends that all diagnoses [dx 2- dx 25] should be counted.

Data source: Hospital Discharge Database [HDD].
Data reflects Rhode Island resident events that were treated in Rhode Island hospitals.

Denominator is from the 2010 Census.

Notes - 2011
Data for 2011 is provisional but data shows a sigificant decline in the rate of nonfatal injuries due to motor vechicle crashes among children aged 15 through 24. The rate per 100,000 for 2010 was 86.9 compared to the 2011 rate of 78.3.

Notes - 2010
Starting with 2010, Rhode Island adopted the requirements listed in the 'State Injury Indicators Report - 2010 Data,' published by CDC.
The publication recommends that all diagnoses [dx 2- dx 25] should be counted. .

Data source: Hospital Discharge Database [HDD].
Data reflects Rhode Island resident events that were treated in Rhode Island hospitals.

Denominator is from the 2010 Census..

Narrative:
/2014/ The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years in Rhode Island appears to be going down //2014//. HEALTH's Safe Rhode Island (SRI) partnered with the Traffic Safety Coalition (TSC) and the Injury Prevention Center at RI Hospital to successfully advocate for the passage of legislation eliminating a major loophole in the state's drunk driving laws to cover individuals who refuse to submit to a breathalyzer test. The social host law was also strengthened to deter adults who knowingly provide alcohol to minors on their property. Rhode Island's Graduated Driver Licensing (GDL) law was improved to include a limit on cell phone use by youth less than 18 years while driving and a ban on texting while driving. Additionally, a voluntary two hour parent education class was integrated into the Community College of Rhode Island Driver Education Program curriculum. /2013/ The governor signed a primary seat belt law on June 30, 2011. This law allows police officers to ticket a driver solely on the basis that the driver is not wearing a seatbelt and makes enforcement of the law that covers children up to 18 years more likely //2013//.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 05A - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	22.3	24.1	22.7	26.6	28.1
Numerator	881	962	907	1062	1119
Denominator	39428	39889	39889	39889	39889
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012
Data for 2012 reflects an increase from previous years. A three year average rate for 2010 - 2012 is 25.8 per 1,000.
Denominator from the 2010 Population Census

Notes - 2011
Data for 2011 indicate an increase from previous years. However, a three year average [2009-2011], shows the rate per 1,000 women aged 15 through 19 with a reported case of chlamydia is 24.5..

Denominator from the 2010 Population Census.

Notes - 2010
Although there was a small decrease in 2010, this measure has been relatively stable over the three year period from 2008 through 2010.

Denominator from the 2010 Population Census.

Narrative:
/2014/ The rate of 1,000 women aged 15-19 years witha reported case of Chlamydia appears to be going up since 2010 //2014//. /2013/ The DCFHE is responsible for monitoring, tracking and working to improve the health of school age children through child and adolescent medical home efforts and administration of the state's Title X Family Planning Program. The Family Planning Program is a member of the Region I Infertility Prevention Project (IPP), which is a collaboration between the Centers for Disease Control (CDC) and the Office of Population Affairs (OPA). The overall goal of IPP is to assess and reduce the prevalence of Chlamydia and gonorrhea and reduce related sequelae such as pelvic inflammatory disease (PID), infertility and ectopic pregnancy. Positive Chlamydia and gonorrhea cases are reported by the RI State Laboratory to the STD Program and IPP. This data is critical to being able to identify the needs of subpopulations and to develop effective planning and prevention interventions. The information is shared with community partners through the publication of our annual Title V application, 5 Year Needs Assessment, Annual Needs Assessment Summary and materials developed by the STD program. The data is used to identify trends in subpopulations and is reported in the context of contributing factors that impact the numbers and rates. In order to measure the effectiveness of interventions and to determine progress towards meeting goals, the data is monitored over time //2013//.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 05B - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	8.2	9.1	8.7	10.7	10.9
Numerator	1468	1590	1518	1873	1913
Denominator	178493	174758	174758	174758	174758
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012
There was a slight increase in the rate of Chlamydia for women aged 20 throught 44 from 10.7 per 1,000 in 2011 to 10.9 in 2012.

Denominator from the 2010 Population Census.

Notes - 2011
There was a significant increase in the rate of Chlamydia for women aged 20 throught 44 from 8.7 per 1,000 in 2010 to 10.7 in 2011.

Denominator from the 2010 Population Census.

Notes - 2010
The rate of Chlamydia for women aged 20 through 44 decreased from 9.1 per 1,000 in 2009 to 8.7 per 1,000 in 2010.

Denominator from the 2010 Population Census.

Narrative:
/2014/ The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia appears to be going up since 2010 //2014//. /2013/ The DCFHE is responsible for monitoring, tracking and working to improve the health of school age children through child and adolescent medical home efforts and administration of the state's Title X Family Planning Program. The Family Planning Program is a member of the Region I Infertility Prevention Project (IPP), which is a collaboration between the Centers for Disease Control (CDC) and the Office of Population Affairs (OPA). The overall goal of IPP is to assess and reduce the prevalence of Chlamydia and gonorrhea and reduce related sequelae such as pelvic inflammatory disease (PID), infertility and ectopic pregnancy. Positive Chlamydia and gonorrhea cases are reported by the RI State Laboratory to the STD Program and IPP. This data is critical to being able to identify the needs of subpopulations and to develop effective planning and prevention interventions. The information is shared with community partners through the publication of our annual Title V application, 5 Year Needs Assessment, Annual Needs Assessment Summary and materials developed by the STD program. The data is used to identify trends in subpopulations and is reported in the context of contributing factors that impact the numbers and rates. In order to measure the effectiveness of interventions and to determine progress towards meeting goals, the data is monitored over time //2013//.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	10959	8362	1216	143	404	25	809	0
Children 1 through 4	46489	36013	4981	631	1652	93	3119	0
Children 5 through 9	60440	48150	5948	822	2068	140	3312	0
Children 10 through 14	63824	51962	6148	807	1935	148	2824	0
Children 15 through 19	80046	65294	7679	899	2998	166	3010	0
Children 20 through 24	82167	67456	7309	825	4043	171	2363	0
Children 0 through 24	343925	277237	33281	4127	13100	743	15437	0

Notes - 2014

Narrative:
As part of a needs assessment process, the DCFHE, in partnership with the Center for Health Data and Analysis tracks, on an annual basis, subpopulation trends in age group, race, and ethnicity in order to conduct cross-tabulations of factors that impact health and target prevention activities in populations most in need. For example, teen birth rates are highest among Hispanic populations, which also have high rates of poverty. Teen pregnancy prevention efforts, therefore,

are focused on the Hispanic community. Data are drawn from Vital Records, Department of Administration Statewide Planning, U.S. Bureau of the Census, and other population estimate sources. This information is used to calculate rates of various maternal and child health indicators. The information is shared with community partners through the publication of our annual Title V application, 5 Year Needs Assessment, and Annual Needs Assessment Summary. Data are also reported through our partnership with Rhode Island Kids Count, which publishes an annual Fact book on child well being. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

/2013/ Some of the new 10-year census data (2010) are now available by age, race and ethnicity, and additional data will be made available during CY2012.//2013//

In addition, date of birth, race, and ethnicity are collected at birth in the integrated electronic birth certificate/developmental risk assessment system (VR2000) and stored in KIDSNET. Age, and when possible, race and ethnicity are also collected in KIDSNET when new records are opened for children not born in Rhode Island. ***/2014/ The electronic birth certificate system will be upgraded to meet the 2003 standards //2014//.***

Survey data including PRAMS, TWOS, Youth Risk Behavior Survey, and Behavioral Risk Factor Surveillance, vital records data, maternal and child health program data, hospital inpatient and emergency room data, and STD data enumerated by age, race and ethnicity are available for data analysis. WIC, the Immunization Program, the newborn screening programs, healthy childcare programs, adolescent health, and other MCH programs use data enumerated by age, race and ethnicity to identify coverage rates and gaps in service, target outreach and service delivery, evaluate effectiveness of program activities, prepare of state plans, rank relative community needs, identify disparities and needs by race and ethnicity, and disseminate information to key stakeholders.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	8316	2643	0
Children 1 through 4	35777	10712	0
Children 5 through 9	47915	12525	0
Children 10 through 14	51608	12216	0
Children 15 through 19	66220	13826	0
Children 20 through 24	69612	12555	0
Children 0 through 24	279448	64477	0

Notes - 2014

Narrative:
As part of a needs assessment process, the DCFHE, in partnership with the Center for Health Data and Analysis tracks, on an annual basis, subpopulation trends in age group, race, and ethnicity in order to conduct cross-tabulations of factors that impact health and target prevention activities in populations most in need. For example, teen birth rates are highest among Hispanic

populations, which also have high rates of poverty. Teen pregnancy prevention efforts, therefore, are focused on the Hispanic community. Data are drawn from Vital Records, Department of Administration Statewide Planning, U.S. Bureau of the Census, and other population estimate sources. This information is used to calculate rates of various maternal and child health indicators. The information is shared with community partners through the publication of our annual Title V application, 5 Year Needs Assessment, and Annual Needs Assessment Summary. Data are also reported through our partnership with Rhode Island Kids Count, which publishes an annual Fact book on child well being. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

/2013/ Some of the new 10-year census data (2010) are now available by age, race and ethnicity, and additional data will be made available during CY2012.//2013//

In addition, date of birth, race, and ethnicity are collected at birth in the integrated electronic birth certificate/developmental risk assessment system (VR2000) and stored in KIDSNET. Age, and when possible, race and ethnicity are also collected in KIDSNET when new records are opened for children not born in Rhode Island. ***/2014/ The electronic birth certificate system will be upgraded to meet the 2003 standards //2014//.***

Survey data including PRAMS, TWOS, Youth Risk Behavior Survey, and Behavioral Risk Factor Surveillance, vital records data, maternal and child health program data, hospital inpatient and emergency room data, and STD data enumerated by age, race and ethnicity are available for data analysis. WIC, the Immunization Program, the newborn screening programs, healthy childcare programs, adolescent health, and other MCH programs use data enumerated by age, race and ethnicity to identify coverage rates and gaps in service, target outreach and service delivery, evaluate effectiveness of program activities, prepare of state plans, rank relative community needs, identify disparities and needs by race and ethnicity, and disseminate information to key stakeholders.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	6	2	0	0	0	0	0	4
Women 15 through 17	210	88	22	4	2	0	13	81
Women 18 through 19	547	238	54	15	17	0	37	186
Women 20 through 34	8206	5359	577	39	402	0	241	1588
Women 35 or older	1789	1300	113	7	91	0	30	248
Women of all ages	10758	6987	766	65	512	0	321	2107

Notes - 2014

Narrative:
As part of a needs assessment process, the DFCHE in partnership with the Center for Health Data and Analysis, tracks, on an annual basis, live births to women (of all ages) enumerated by maternal age, race, and ethnicity. These data are used to calculate fertility rates among women of all ages. They are also used to calculate overall pregnancy rates and teen pregnancy rates. Data are drawn from Vital Records. The information is shared with community partners through the publication of our annual Title V application, 5 Year Needs Assessment, and Annual Needs Assessment Summary. Data are also reported through our partnership with Rhode Island Kids Count, which publishes an annual Factbook on child wellbeing. WIC and other MCH programs use data enumerated by maternal age, race and ethnicity to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions, to determine progress towards meeting goals, and in the preparation of state plans and for ranking relative community needs

All live births, maternal date of birth, race, and ethnicity are collected in the integrated electronic birth certificate/developmental risk screening system (VR2000) and stored in KIDSNET. ***/2014/ The electronic birth certificate system will be upgraded to meet the 2003 standards //2014//.***

/2013/ The Maternal, Infant and Early Childhood Home Visiting Initiative has relied extensively on this data for planning for expanded home visiting in Rhode Island //2013//. ***/2014/ The three evidence-based programs implemented through MIECHV also collect data on mother's race and ethnicity and are entered into Efforts to Outcomes (ETO) //2014//.***

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	1	5	0
Women 15 through 17	101	104	5
Women 18 through 19	319	221	7
Women 20 through 34	6143	1849	214
Women 35 or older	1449	270	70
Women of all ages	8013	2449	296

Notes - 2014

Narrative:
As part of a needs assessment process, the DFCHE in partnership with the Center for Health Data and Analysis, tracks, on an annual basis, live births to women (of all ages) enumerated by maternal age, race, and ethnicity. These data are used to calculate fertility rates among women of all ages. They are also used to calculate overall pregnancy rates and teen pregnancy rates. Data are drawn from Vital Records. The information is shared with community partners through the publication of our annual Title V application, 5 Year Needs Assessment, and Annual Needs Assessment Summary. Data are also reported through our partnership with Rhode Island Kids

Count, which publishes an annual Factbook on child wellbeing. WIC and other MCH programs use data enumerated by maternal age, race and ethnicity to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions, to determine progress towards meeting goals, and in the preparation of state plans and for ranking relative community needs

All live births, maternal date of birth, race, and ethnicity are collected in the integrated electronic birth certificate/developmental risk screening system (VR2000) and stored in KIDSNET. ***/2014/ The electronic birth certificate system will be upgraded to meet the 2003 standards //2014//.***

/2013/ The Maternal, Infant and Early Childhood Home Visiting Initiative has relied extensively on this data for planning for expanded home visiting in Rhode Island //2013//. ***/2014/ The three evidence-based programs implemented through MIECHV also collect data on mother's race and ethnicity and are entered into Efforts to Outcomes (ETO) //2014//.***

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	64	34	12	0	2	0	3	13
Children 1 through 4	4	2	0	0	0	0	2	0
Children 5 through 9	9	8	1	0	0	0	0	0
Children 10 through 14	6	5	0	0	0	0	0	1
Children 15 through 19	16	11	3	0	0	0	0	2
Children 20 through 24	39	25	5	0	0	0	0	9
Children 0 through 24	138	85	21	0	2	0	5	25

Notes - 2014

Narrative:
As part of a needs assessment process, the DCFHE's in partnership with the Center for Health Data and Analysis, tracks, on an annual basis, deaths to infants and children aged 0 through 24 years enumerated by age subgroup, race, and ethnicity in order to conduct cross-tabulations of factors that impact health and target prevention activities to populations most in need. The DCFHE tracks data by cause of death, age, and geographical areas and looks at insurance status and other variables. Data are drawn from Vital Records. The DCFHE and the Center for Health Data and Analysis works with programs to identify causes of death and to identify effective prevention strategies. The Center for Health and Data and Analysis and the SafeRI- Violence and Injury Prevention Program participates on the Rhode Island Child Death Review Team focused on preventable deaths among all children and adolescents. The information is shared with

community partners through the publication of our annual Title V application, 5 Year Needs Assessment, and Annual Needs Assessment Summary. Data are also reported through our partnership with Rhode Island Kids Count, which publishes an annual Factbook on child wellbeing. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

Deaths to infants that occur prior to discharge from a maternity hospital are collected in the integrated electronic birth certificate/developmental risk assessment system (VR2000) along with date of birth and race/ethnicity data and stored in KIDSNET. KIDSNET also works with Vital Records and other processes to record infant and child death in KIDSNET. ***/2014/ The electronic birth certificate system will be upgraded to meet the new standards //2014//.***

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	50	13	1
Children 1 through 4	4	0	0
Children 5 through 9	7	2	0
Children 10 through 14	5	1	0
Children 15 through 19	13	2	1
Children 20 through 24	31	7	1
Children 0 through 24	110	25	3

Notes - 2014

Narrative:
As part of a needs assessment process, the DCFHE's in partnership with the Center for Health Data and Analysis, tracks, on an annual basis, deaths to infants and children aged 0 through 24 years enumerated by age subgroup, race, and ethnicity in order to conduct cross-tabulations of factors that impact health and target prevention activities to populations most in need. The DCFHE tracks data by cause of death, age, and geographical areas and looks at insurance status and other variables. Data are drawn from Vital Records. The DCFHE and the Center for Health Data and Analysis works with programs to identify causes of death and to identify effective prevention strategies. The Center for Health and Data and Analysis and the SafeRI- Violence and Injury Prevention Program participates on the Rhode Island Child Death Review Team focused on preventable deaths among all children and adolescents. The information is shared with community partners through the publication of our annual Title V application, 5 Year Needs Assessment, and Annual Needs Assessment Summary. Data are also reported through our partnership with Rhode Island Kids Count, which publishes an annual Factbook on child wellbeing. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

Deaths to infants that occur prior to discharge from a maternity hospital are collected in the integrated electronic birth certificate/developmental risk assessment system (VR2000) along with date of birth and race/ethnicity data and stored in KIDSNET. KIDSNET also works with Vital Records and other processes to record infant and child death in KIDSNET. ***/2014/ The electronic birth certificate system will be upgraded to meet the new standards //2014//.***

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown	Specific Reporting Year
All children 0 through 19	261764	209781	25972	3302	9057	578	13074	0	2010
Percent in household headed by single parent	35.0	26.0	45.0	0.0	30.0	0.0	0.0	48.0	2011
Percent in TANF (Grant) families	4.9	11.7	7.0	0.3	0.9	0.0	0.0	80.1	2012
Number enrolled in Medicaid	95248	15906	4858	286	1048	0	0	73150	2012
Number enrolled in SCHIP	14790	3809	776	43	256	0	0	9906	2012
Number living in foster home care	1567	1018	247	15	23	0	167	97	2012
Number enrolled in food stamp program	64866	10703	3957	259	649	0	0	49298	2012
Number enrolled in WIC	21320	14769	3576	118	706	294	1857	0	2012
Rate (per 100,000) of juvenile crime arrests	3060.0	2440.0	8174.0	0.0	2005.0	0.0	0.0	3760.0	2012
Percentage of high school drop-outs (grade 9 through 12)	12.0	9.0	20.0	28.0	10.0	0.0	0.0	0.0	2012

Notes - 2014
Data source for children aged 0 through 19 is the 2010 Census.

Data source Is the Kids Count Factbook for 2013.

Data reflects percent of children under the age of 18, living with one parent in Rhode Island between 2009 and 2011. Due to high numbers of unknowns, race and ethnicity are unreliable

Data source Is the Kids Count Factbook for 2013.

Data reflects percent of children under the age of 18, in families receiving cash assistance in Rhode Island as of December 1, 2012 (RI Works). Due to high numbers of unknowns, race and ethnicity are unreliable.

Data source Is the Kids Count Factbook for 2013.

Data reflects children under the age of 19, receiving medical assistance as of December 31, 2012. Due to high numbers of unknowns, race and ethnicity are unreliable.

Data source is the Department of Human Services for children aged 8 - 18. In Rhode Island the CHIP program has always served uninsured children 8 thru 18. Infants and children under 8 are covered under Medicaid.

Data source Is the Kids Count Factbook for 2013.

Data reflects children under the age of 18, receiving SNAP benefits [Food Stamps] as of October, 2012. Due to high numbers of unknowns, race and ethnicity are unreliable

Data source is the RI WIC Program for infants, children and women up to the age of 19, as of December 31, 2012.

Data source Is the Kids Count Factbook for 2013.

Data reflects children under the aged 10 thru 18, referred to Family Court during 2012. Race and ethnicity were estimated.

Data source Is the Kids Count Factbook for 2013.

Data reflects Rhode Island four-year high schoold dropout rates for the class of 2012. Race and ethnicity were estmiated.

Data source is the Department for Children, Youth and Families.
Data reflects children aged 0 through 19 in foster care as of December 31, 2012.

Narrative:
As part of a needs assessment process, the DCFHE tracks subpopulation trends in age group, race, and ethnicity in order to conduct cross-tabulations of factors that impact health and target prevention activities in populations most in need. The DCFHE in partnership with the Center for Health Data and Analysis tracks, on an annual basis, infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various state programs enumerated by race and ethnicity. Data are drawn from program reports, the U.S. Bureau of the Census, Rhode Island Kids Count, the Department of Human Services/Medicaid, Juvenile Justice, and Vital Records. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

Race/ethnicity data are collected at birth in the integrated electronic birth certificate/developmental risk assessment system (VR2000) and stored in KIDSNET. When

possible, race and ethnicity are also collected in KIDSNET when new records are opened for children not born in Rhode Island. KIDSNET includes program-level data for children born on or after January 1, 1997 for the following programs: Early Intervention, First Connections (home visiting), WIC, Immunization, Lead Poisoning Prevention, and Newborn Screening (metabolic, hearing, and developmental risk). KIDSNET generates program data enumerated by race and ethnicity for program use. ***/2014/ The electronic birth certificate system will be upgraded to meet the 2003 standards //2014//.***

WIC, the Immunization Program, early childhood programs including Successful Start and Project Launch, Adolescent Health, and other MCH programs use data enumerated by race and ethnicity to support federally funded Vaccine for Children (VFC) activities, identify coverage rates and gaps in service, target outreach and service delivery, evaluate effectiveness of program activities, prepare state plans, rank relative community needs, identify disparities and needs by race and ethnicity, determine translation needs/requirements for educational materials, develop recommendations for early childhood systems and services about targeting resources to areas of highest need, and disseminate information to key stakeholders.

Access to the Department of Human Services data warehouse beginning in 2011 will increase capacity to report miscellaneous data relevant to MCH programs enumerated by race and ethnicity.

/2013/ Heights, weights and BMI for WIC participants aged less than six can now be enumerated by race and ethnicity in KIDSNET //2013//. ***/2014/ The capacity to record and enumerate developmental screening to young children was added to KIDSNET during 2012//2014//.***

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	209836	51922	0	2010
Percent in household headed by single parent	30.0	46.0	24.0	2012
Percent in TANF (Grant) families	19.8	14.1	66.1	2012
Number enrolled in Medicaid	22193	14573	58482	2012
Number enrolled in SCHIP	0	2563	14790	2012
Number living in foster home care	1071	409	87	2012
Number enrolled in food stamp program	15503	11092	38271	2012
Number enrolled in WIC	12475	8845	0	2012
Rate (per 100,000) of juvenile crime arrests	3085.0	2751.0	3760.0	2012
Percentage of high school drop-outs (grade 9 through 12)	81.0	19.0	0.0	2012

Notes - 2014
Data source is the 2010 Census.

For data source and program information, see notes provided above in race breakdown.

For data source and program information, see notes provided above in race breakdown.

For data source and program information, see notes provided above in race breakdown.

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Narrative:
As part of a needs assessment process, the DCFHE tracks subpopulation trends in age group, race, and ethnicity in order to conduct cross-tabulations of factors that impact health and target prevention activities in populations most in need. The DCFHE in partnership with the Center for Health Data and Analysis tracks, on an annual basis, infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various state programs enumerated by race and ethnicity. Data are drawn from program reports, the U.S. Bureau of the Census, Rhode Island Kids Count, the Department of Human Services/Medicaid, Juvenile Justice, and Vital Records. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

Race/ethnicity data are collected at birth in the integrated electronic birth certificate/developmental risk assessment system (VR2000) and stored in KIDSNET. When possible, race and ethnicity are also collected in KIDSNET when new records are opened for children not born in Rhode Island. KIDSNET includes program-level data for children born on or after January 1, 1997 for the following programs: Early Intervention, First Connections (home visiting), WIC, Immunization, Lead Poisoning Prevention, and Newborn Screening (metabolic, hearing, and developmental risk). KIDSNET generates program data enumerated by race and ethnicity for program use. ***/2014/ The electronic birth certificate system will be upgraded to meet the 2003 standards //2014//.***

WIC, the Immunization Program, early childhood programs including Successful Start and Project Launch, Adolescent Health, and other MCH programs use data enumerated by race and ethnicity to support federally funded Vaccine for Children (VFC) activities, identify coverage rates and gaps in service, target outreach and service delivery, evaluate effectiveness of program activities, prepare state plans, rank relative community needs, identify disparities and needs by race and ethnicity, determine translation needs/requirements for educational materials, develop recommendations for early childhood systems and services about targeting resources to areas of highest need, and disseminate information to key stakeholders.

Access to the Department of Human Services data warehouse beginning in 2011 will increase capacity to report miscellaneous data relevant to MCH programs enumerated by race and ethnicity.

/2013/ Heights, weights and BMI for WIC participants aged less than six can now be enumerated by race and ethnicity in KIDSNET //2013//. ***/2014/ The capacity to record and enumerate developmental screening to young children was added to KIDSNET during 2012//2014//.***

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	240022
Living in urban areas	254072
Living in rural areas	0
Living in frontier areas	0
Total - all children 0 through 19	254072

Notes - 2014

Narrative:
As part of a needs assessment process, the DCFHE in partnership with CHDA tracks, on an annual basis, the geographic living area for all resident children aged 0 through 19 years in order to conduct cross-tabulations by geographic area to target prevention activities. Data are drawn from Vital Records and Census data. HEALTH has implemented a geographical information system for use by all staff. Databases are gradually being geo-coded for mapping purposes. The information is shared with community partners through the publication of our annual Title V application, 5 Year Needs Assessment and Annual Needs Assessment Summary. Data are also reported through our partnership with Rhode Island Kids Count, which publishes an annual Fact Book. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

Address at the time of birth is collected at birth in the integrated electronic birth certificate/developmental risk assessment system (VR2000) and stored in KIDSNET. When possible, address information is also collected in KIDSNET when new records are opened on children not born in RI. Address information is updated by KIDSNET users such as home visitors, the lead program, primary care providers, and others aware of address changes. KIDSNET data can be analyzed at the zip code, region, or city/town level. This data can then be shared with agencies and local coalitions working to address public health issues within communities. Geographic data has also been used to inform policymakers working on disaster plans such as pandemic flu. KIDSNET, in collaboration with the CHDA GIS Program, now has the capacity to report data by any geographic level allowing for refined geographic analysis and production of maps. ***/2014/ A report that maps MCH risk factors has been published in the RI DataHub. A home visiting data story is in development for the DataHub. A KIDSNET data book that maps maternal and child health data using GIS will be published //2014//.***

The DCFHE, in partnership with the CHDA, has an established practice of comparing data in core cities (where childhood poverty is 15% or greater) compared to other areas in the state.

WIC, First Connections, MIECHV, and other MCH programs use geographic data to monitor coverage rates and gaps in service in cities and towns, target outreach and service delivery, evaluate effectiveness of program activities, prepare state plans, rank relative community needs, identify disparities and needs by race and ethnicity, target resources to areas of high need and density, and disseminate information to key stakeholders.

/2014/ Some of the new 10-year census data (2010) are now available by age, race and ethnicity, an additional data were made available during 2012 //2014//.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	1036541
Percent Below: 50% of poverty	5.2
100% of poverty	13.5
200% of poverty	30.7

Notes - 2014

Narrative:
As part of a needs assessment process, the DCFHE in partnership with the Center for Health Data and Analysis tracks, on an annual basis, the percent of the population (state and child) at various levels of the federal poverty level in order to conduct cross-tabulations by poverty to target prevention activities in areas most in need. Poverty is a risk factor for nearly every poor health outcome and therefore must be addressed as part of strategic planning to improve health and wellbeing of maternal and child populations. For example, poverty is a risk factor for teen pregnancy and school failure. Teen pregnancy prevention efforts, therefore, must incorporate strategies to give youth hope for the future and skills to meet the demands of a 21st century workforce. Data are drawn from the U.S. Bureau of the Census and other survey and program data. The information is shared with community partners through the publication of our annual Title V application, 5 Year Needs Assessment and Annual Needs Assessment Summary. Data are also reported through our partnership with Rhode Island Kids Count, which publishes an annual Factbook on child wellbeing. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

WIC, Early Childhood, Adolescent Health, and other MCH programs use poverty data to monitor coverage rates and gaps in service, target outreach and service delivery, evaluate effectiveness of program activities, preparation of state plans, ranking relative community needs, identify disparities and needs by race and ethnicity, target resources to areas of highest need and density, develop recommendations, and disseminate information to key stakeholders

/2014/ Some of the new 10-year census data (2010) are now available by age, race and ethnicity, an additional data were made available during 2012 //2014//.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	254072
Percent Below: 50% of poverty	8.1
100% of poverty	19.9

200% of poverty	38.7

Notes - 2014

Narrative:
As part of a needs assessment process, the DCFHE in partnership with the Center for Health Data and Analysis tracks, on an annual basis, the percent of the population (state and child) at various levels of the federal poverty level in order to conduct cross-tabulations by poverty to target prevention activities in areas most in need. Poverty is a risk factor for nearly every poor health outcome and therefore must be addressed as part of strategic planning to improve health and wellbeing of maternal and child populations. For example, poverty is a risk factor for teen pregnancy and school failure. Teen pregnancy prevention efforts, therefore, must incorporate strategies to give youth hope for the future and skills to meet the demands of a 21st century workforce. Data are drawn from the U.S. Bureau of the Census and other survey and program data. The information is shared with community partners through the publication of our annual Title V application, 5 Year Needs Assessment and Annual Needs Assessment Summary. Data are also reported through our partnership with Rhode Island Kids Count, which publishes an annual Factbook on child wellbeing. Data are used to identify trends in subpopulations and are reported in the context of contributing factors that impact the numbers and rates. The data are monitored over time to measure the effectiveness of interventions and to determine progress towards meeting goals.

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/2014/ Some of the new 10-year census data (2010) are now available by age, race and ethnicity, an additional data were made available during 2012 //2014//.

F. Other Program Activities

F. Other Program Activities

DCFHE initiatives and activities that were not fully discussed within the context of the National and State Performance Measures are described below.

Toll-Free Department of Health Information Line

/2013/ Health Information Line (HIL) is a statewide toll-free telephone resource for Rhode Islanders. Bi-lingual information specialists answer families' questions in English, Spanish and Portuguese about HEALTH programs, as well as about a wide variety of health topics, such as mold and mildew. Calls in other languages are answered using a contracted vender for language access. Staff refers callers to appropriate community resources. Callers to the HIL include consumers, health care providers, school personnel, and community-based agencies. In addition, HIL specialists help health care professionals renew their licenses over the telephone. To better assist callers, the specialists have been provided with access to several HEALTH databases including vital records, KIDSNET, and L2K (the health care professional licensing database).

The Rhode Island Health Information Exchange and KIDSNET

/2014/ CurrentCare, Rhode Island's Health Information Exchange (HIE), is operated by the state's designated health information organization the Rhode Island Quality Institute (RIQI). CurentCare accepts data electronically from hospitals via an HL7 Admit/Discharge/Transfer interface, from providers offices via a Continuity of Care Document sent via the secure DIRECT email protocol, and laboratory results via an HL7 Observation/Result interface. CurrentCare implements a hybrid HIE model. Most data are stored in a central repository the primary exception being laboratory results which are obtained real-time as needed.

CurrentCare utilizes an opt-in model of consent. Currently 293,000 of a population of approximately one million are enrolled; approximately 160,000 individuals have data in the system. 9 hospitals are currently sending data with an estimated 11 by the end of calendar year (CY) 2013. One hundred nineteen sites are currently viewing data in CurrentCare with an estimated 162 by the end of CY 2013. Eighteen provider offices are sending data with an estimated 37 by the end of CY 2013.

In addition to the ability to collect and view data a "hospital alert" service has been implemented. This service sends an email from CurrentCare to an individual's primary care provider, assuming one is indicated, when a patient is admitted to a hospital or its emergency department. The alert message is sent via the secure DIRECT email protocol.

KIDSNET is actively participating in CurrentCare as a Data Sharing Partner. Business process analysis and system design meetings are underway to develop bi-directional interfaces between KIDSNET and CurrentCare. Staffs from RIQI, KIDSNET and HLN, the KIDSNET software provider, are participating in these sessions. The team expects to complete design documents during calendar year 2013. This project also benefits from the participation of RIQI's medical director to ensure a pediatric office workflow is improved by any new interface. In an independent project the provider CCD transmission is being evaluated as a source of data for other public health purposes such as BMI, birth defects, asthma and diabetes surveillance. KIDSNET, the system and the staff, are being utilized in the testing of this concept and can be expected to benefit from this project.

Other CurrentCare projects, independent of KIDSNET, include interfaces with EMS ambulance run reports to transmit and store run report; an analysis/review of the workflow for Latent Tuberculosis Infection (LTBI) and the hand off of patients between specialty clinics and primary care providers; discussions and analysis of a shared provider directory; as well as utilizing CurrentCare as a source of data to support public health projects. It can be expected KIDSNET will benefit directly or indirectly from all those projects.

Center for Health Equity and Wellness (CHEW) grants

The elimination of health disparities in the state continues to be a major challenge in the face of the economic downturn and cuts to public safety net services. The residents of the state's core urban communities have the highest rates of poverty and are at risk in almost every category. In response, the DCFHE issued an $800,000 integrated MCH/Chronic Disease RFP for three years to initiate environmental system policy changes in the areas of social, political, physical, and environmental determinants of health through a community engagement process to make active living an easier choice for all residents. The RFP included two components:

Component 1: Healthy and Safe Sustainable Communities: The goal of this component is to support the advancement at the local level of the National Strategic Direction 'to create, sustain, and recognize communities that promote health and wellness through prevention". Applicants were asked to develop collaborate to develop strategies and

policies that impact the availability of resources to meet daily needs (housing, education, job opportunities, food security) that impact the community structure (parks, transportation) that impact the natural environment.

Component 2: Implementation of evidence-based programs addressing chronic disease and its risk factors and maternal and child health priorities: Evidence-based public health and education and promotion programs should address health improvements that can be achieved through population-based as well as individual actions, systems-based, environmental, health service, or policy interventions. These interventions will further advance, at the local level, the National Prevention Strategy and Rhode Island MCH priorities. Awards were issued @ $100,000 per award to eight community-based organizations. The projects were implemented on January 1, 2013. The community organizations that were funded, along with a brief description of each program is as follows:

Component 1

City of Providence: To increase access to healthy foods by establishing a program to turn unused city property into urban farms.

Olneyville Housing Corporation: To transform land an property to affordable, quality housing and construct and/or maintain parks and other open spaces for recreation and to encourage walking, biking, and use of RIPTA.

West Elmwood Housing Development Corporation: To reduce diet related health disparities and improve eating behaviors of West End residents through the implementation of a multi-component neighborhood-wide "Sankofa" intervention.

Component 2:

West Elmwood Housing Development Corporation: To build environment, systems and policy changes through the development of pocket parks, formation and facilitation of a neighborhood policy group, health and financial education and physical activities.

Clinic Esperanza: To implement a self-management chronic disease education program titled "A Place to Be Healthy".

Family Service of Rhode Island: To replicate the Harlem "Children's Zone Asthma Initiative" in neighborhoods in lower South Providence.

The Providence Center: To provide families in Providence, Pawtucket, and Central Falls with "Incredible Years" parenting groups.

The Providence Plan: To provide families in Providence, Pawtucket, and Central Falls with "Incredible Years" parenting groups.

Chronic Conditions Integrated Work Force System

The DCFHE created a coordinated system to provide evidence-based and best practice education to activate patients and improve patient skills necessary to self-manage their chronic conditions. This system is comprised of a Chronic Conditions Workforce Collaborative (CCWC), which is a partnership between multiple DCFHE evidence-based programs (including the OSHCN and the OMH) and other partners in RI who work on the management of chronic conditions. CCWC is building a skilled work force of expertly trained staff both professional and community health workers who provide Stanford University self-management programs, chronic disease management programs, and

patient navigation.

The CCWC supports RI's health care movement toward integrated health care and patient centered medical homes. The 2011 Patient Centered Medical Home NCQA standards require patient self-care support and access to community resources. The CCWC workforce provides a resource to providers, patients, and payers which links to the practice team and leads to productive interactions between the patient and the practice team. Components of the system include a centralized referral system with secure fax and email to HEALTH; follow up with the patient to assist with access to CCWC resources, and communication back to the practice concerning the patient experience //2014//.

G. Technical Assistance

/2013/ The following information represents a preliminary idea of the programmatic areas in which Rhode Island's Title V Program would like technical assistance (TA), consultation, or capacity building activities //2013//.

/2014/ Request #1

This TA Request Addresses: State Performance Measure #4; National Performance Measures #2-6

Description: Dare to Dream Conference. Since its inception in 2009, the Maternal and Child Health Bureau has partnered with RI's Office of Special Health Care Needs in the Dare to Dream Conference. Technical Assistance funds have been sought and accessed to fund the keynote speaker for the Annual Dare to Dream Conference Speaker. The Annual Dare to Dream Conference is held on a college campus and includes a youth motivational speaker and peer-led presentations from students with disabilities. Since 2009, Rhode Island's annual Dare to Dream conference has touched the lives of thousands of students. Teachers, counselors, transition coordinators, and youth leaders continue to support the opportunity the conference provides for students to spend time reflecting on who they are, where they are going in the future, and how they might get there.

Justification: RI's State Priority #4 is to increase the social and emotional health of children and youth with special needs as measured by comparing students with disabilities and their typical peers on affect measures of the YRBS. This also addresses NPM # 2-6. RI's approach to addressing these disparities in social and emotional health is to promote opportunities for positive youth development, meaningful inclusion in school and community based activities, and assisting youth in the formation of leadership skills. Through the conference, students understand the power and responsibility of healthy decision making, learn effective critical thinking and conflict resolution skills, and practice healthy ways to deal with freedom, loneliness. The OSHCN is developing student leaders for youth membership advisory committees, policy discussions, boards and speaking bureaus.

TA provider and organization: To Be Determined

Request #2

This TA Request Addresses: State Performance Measure #4; National Performance Measures #2-6

Description: Parent Professional Partnership Conference. This is an annual conference sponsored by the RI Parent Information Network, the RI Department of Health and Family Voices that attracts approximately 250 parents and professionals in RI. The conference leads

participants through important elements of a coordinated system of care, equips them with valuable resources and provides an opportunity to meet with state program administrators. The TA request will pay for the keynote speaker.

Justification: RI's State Priority #4 is to increase the social and emotional health of children and youth with special needs as measured by comparing students with disabilities and their typical peers on affect measures of the YRBS. This also addresses NPM # 2-6. RI's approach to addressing these disparities in social and emotional health is to promote opportunities for positive youth development, meaningful inclusion in school and community based activities, and assisting youth in the formation of leadership skills. Through the conference, parents and professionals will understand the elements of RI's system of care for CYSHCNs.

TA provider and organization: To Be Determined

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2012		FY 2013		FY 2014	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	1770159	852593	1725040		1627190	
2. Unobligated Balance *(Line2, Form 2)*	1014131	1390436	528230		441255	
3. State Funds *(Line3, Form 2)*	2150006	1680985	2035853		2008389	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	2235641	1401320	1416184		1505729	
6. Program Income *(Line6, Form 2)*	17103557	17929219	19722824		24347698	
7. Subtotal	24273494	23254553	25428131		29930261	
8. Other Federal Funds *(Line10, Form 2)*	71972325	37189172	42605664		36924037	
9. Total *(Line11, Form 2)*	96245819	60443725	68033795		66854298	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2012		FY 2013		FY 2014	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	640019	522935	635405		651473	
b. Infants < 1 year old	2732099	2223881	2759324		2898188	
c. Children 1 to 22 years old	11793204	12545217	13568301		15335751	
d. Children with	2329927	2406287	2446292		2519457	

Special Healthcare Needs						
e. Others	6507858	5250603	5673395		8209246	
f. Administration	270387	305630	345414		316146	
g. SUBTOTAL	24273494	23254553	25428131		29930261	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	170504		171283		79542	
c. CISS	182160		207355		154696	
d. Abstinence Education	0		0		0	
e. Healthy Start	48647		0		0	
f. EMSC	0		0		0	
g. WIC	26287008		0		0	
h. AIDS	8072014		1952052		0	
i. CDC	26766823		28280731		26016668	
j. Education	37000		327828		379070	
k. Home Visiting	0		5907677		4948257	
k. Other						
Administration CYF					618825	
EPA			315401		312559	
Federal Medicaid			398283		418120	
Other (OSHA, NESHAP,					1930997	
Other HRSA					2065303	
DHHS - Admin of CYF			641774			
HRSA			2233751			
other (OSHA, NESHAP)			2169529			
DHHS - Admin of CYF	447618					
DHHS-Admin On Aging	73943					
EPA	355346					
Federal Medicaid	3598470					
HRSA	3534880					
Other (OSHA, NESHAP)	2397912					

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2012		FY 2013		FY 2014	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health Care Services	439002	143222	99495		108993	
II. Enabling Services	657325	468744	323699		405825	
III. Population-Based Services	17587736	17575488	19796746		23394597	
IV. Infrastructure	5589431	5067099	5208191		6020846	

Building Services						
V. Federal-State Title V Block Grant Partnership Total	24273494	23254553	25428131		29930261	

A. Expenditures

V. Budget Narrative

/2014/ Forms 3, 4, 5 provide budget and expenditure data for the 2014 application year, 2013 interim year and 2012 reporting year. Tables are included as an attachment for reference to the budget and expenditure data for the three budget years. For further details on the data and for comparison to previous budget years, refer to Forms 2 -5 of the application.
//2014//

/2011/

Federal Grant Monitoring Procedures

The Division of Community Family Health and Equity (DCFHE) maintains budget documentation for block grant funding/expenditures for reporting consistent with Section 505(a) and section 506(a)(1) for auditing. All federal grants are monitored both within the Division and by HEALTH's Office of Management Services (OMS). The DCFHE Chief Programs Operations meets with DCFHE team and program staff to review spending, performance, and quality assurance issues for each federal grant. The OMS reviews each federal grant monthly for cost and data reporting issues. Any non-compliance, such as delays in progress reports or personnel hiring or lack of billing, requires an immediate response by the DCFHE Chief Programs Operations. Federal financial status reports (FSRs) are due within three months of the close of a federal grant. HEALTH consistently submits FSRs correctly and on-time.

/2013/ CFHE Operations monitors the federal MCH grant monthly by utilizing a detailed grant spreadsheet. The grant spreadsheet tracks expenditures by budget category and by projects funding under each category. Quarterly reviews are performed with project managers to review expenditures and remaining project expenditures through the end of the grant period. If projects are not expected to be fully spent down, project funds may be redirected to support other maternal and child health activities in order to avoid a large unobligated balance. //2013//

HEALTH Policies for Contracting & Purchasing

Any purchase made with federal or state dollars requires prior approval. In addition, all purchases must be approved by the DCFHE Chief Programs Operations. Once approved, the request to purchase form must be signed by OMS staff and then approved by the state Office of Purchasing. There are detailed policies for allowable and non-allowable purchases. These policies include restrictions on types of purchases, like gifts and food, as well as travel guidelines. There are procedures in place for the State of Rhode Island to assure that competition exists between all providers for federal and sate dollars. State departments are allowed to make some purchases without the approval of the Office of Purchasing under certain detailed guidelines.

There are detailed procedures for establishing and monitoring contracts and grants at HEALTH. HEALTH staff cannot enter into a contract with a provider without following certain steps. There are two mechanisms for awarding funds at HEALTH: 1) through a competitive request for proposals (RFP) process and 2) through a grant based on need, legislative requirements, or through a formula funding mechanism. There are detailed requirements for RFPs including appropriate language in the proposals, submission of offers, appeals, public review, and use of minority businesses. An RFP template must be followed for all RFPs and the document is

reviewed by the DCFHE and the OMS before dissemination. The RFP process also requires a formal review of procedures used to select vendors, including an independent session with Office of Purchasing staff. A grant may be awarded to a Rhode Island-based non-profit agency for an identified need, if the agency is solely capable of addressing the need or if there is a legislative requirement to award funds to a particular agency or if HEALTH is awarding funds to all capable agencies through a funding formula. Once approval is received to enter into a grant, DFCFHE staff must then follow procedures for establishing contracts.

Procedures for contract management includes the establishment and modification of contracts, which is the responsibility of the OMS, while the monitoring of contract compliance is a DCFHE responsibility. The DCFHE's Key Administrator meets with DCFHE Team Leads and Contract Management staff to review contract compliance and other administrative issues. Contract monitoring includes approval and signatures for appropriate charges to each contract and contract performance and progress. The DCFHE has the ability to hold back payments or terminate contracts for issues related performance and progress. DCFHE program managers must review the appropriateness of all charges against a contract. Any variation in billing from the established contract must be requested in writing before reimbursements are made. DFH program managers are also responsible for the day-to-day oversights of contracts, monitoring performance, quality assurance, and billing procedures. The program managers regularly conduct performance reviews and customer satisfaction surveys for programs receiving state and federal funds.

Audits & Controls

Audits from both the state Office of the Auditor General and the state Bureau of Audits are conducted at HEALTH annually. The DCFHE has frequently been audited - the WIC Program is audited annually and the Immunization Program and Family Planning were both audited in the recent past.
/2012/ The DCFHE has frequently been audited - the WIC Program is audited annually and the Immunization Program was audited in the recent past.//2012//
HEALTH's OMS conducts audits of DCFHE contracts regularly and monitors payments. In addition to external audits, the DCFHE routinely audits all of its sub-contracted agencies and requires formal audits to be sent to the DCFHE annually.

HEALTH's division managers must submit an annual financial audit review to monitor controls on contracts, personnel, budget, and other administrative policies. These financial audits are reviewed by the state's Financial Officer for compliance with existing state policies.

2009 Expenditures
/2012/ 2010 Expenditures //2012//
/2013/ 2011 Expenditures //2013//
/2014/ 2012 Expenditures //2014//

See the FY09 Expended columns in Form 3 (State MCH Funding Profile), Form 4 (Budget Details by Type of Individuals Served), and Form 5 (State Title V Programs Budget and Expenditures by Type of Services).
/2012/ FY2010 Expended columns on Form 3 (State MCH Funding Profile), Form 4 (Budget Details by Type of Individuals Served), and Form 5 (State Title V Programs Budget and Expenditures by Type of Services).
The Form and Field Notes for the Forms provide additional details and explanations about the amounts shown, including differences between budgeted and expended amounts shown, changes in the level of funding across years, and the sources of State Partnership funds and other Federal funds.//2012//

/2013/ FY2011 Expended columns on Form 3 (State MCH Funding Profile), Form 4 (Budget Details by Type of Individuals Served), and Form 5 (State Title V Programs Budget and

Expenditures by Type of Services).
The Form and Field Notes for the Forms provide additional details and explanations about the amounts shown, including differences between budgeted and expended amounts shown, changes in the level of funding across years, and the sources of State Partnership funds and other Federal funds.//2013//

/2014/ FY2012 Expended columns on Form 3 (State MCH Funding Profile), Form 4 (Budget Details by Type of Individuals Served), and Form 5 (State Title V Programs Budget and Expenditures by Type of Services).
The Form and Field Notes for the Forms provide additional details and explanations about the amounts shown, including differences between budgeted and expended amounts shown, changes in the level of funding across years, and the sources of State Partnership funds and other Federal funds. //2014//

Form 3 (State MCH Funding Profile)
The final unobligated expended for FY09 is more than the original budget estimate by more than 10%.
The reason for this apparent discrepancy is that the original unobligated estimate was too low due to the need to spend carry-over (unobligated funds) first before spending the federal FY09 allocation. An increase in the expended unobligated balance created a decrease in the amount of federal allocation expended. The total amount of FY09 unobligated balance and federal allocation is less than budgeted due to delays in project spending and offsetting MCH projects to other federal grants. The program income expended is less than budgeted due to less childhood and adult immunization spending with restricted funds.
/2012/ The final unobligated expended for FY10 is more than the original budget estimate by more than 10%. Carry-over funding (unobligated funds) were spent prior to spending the federal FY10 allocation. An increase in the expended unobligated balance created a decrease in the amount of federal FY10 allocation expended. The total amount of FY10 unobligated balance and federal allocation is less than budgeted due to delays in project spending and offsetting MCH projects to other federal grants. //2012//
/2013/ One area of the 2011 expenditures warrants further narrative is the increase of unobligated balance expended compared to the federal allocation FY11. The unobligated balance expenditures were greater than the federal allocation expenditures due to the unobligated balances expended prior to the federal allocation. For FY12, MCH projects were budgeted to spend down the unobligated balance and the federal allocation which in turn will shift the expenditures from the unobligated balance to the federal allocation. //2013//

/2014/ The unobligated expended for FY12 is more than the original budget estimate by more than 10%. Carry-over funding was spent prior to spending the federal FY12 allocation. An increase in the expended unobligated balance created a decrease in the amount of federal FY12 allocation expended.

For, 2012, the other federal funding sources had significantly decreased in the reporting expenditure column compared to the budgeted column due to the transfer of the federal Ryan White HIV Care and Treatment program to the Executive Office of Health and Human Services and the Women, Infants and Children (WIC) federal program to the Department of Human Services. Unlike HIV Care and Treatment, the WIC program remains under the Division of Community, Family Health & Equity and the Health Department has been granted access to the use of the WIC accounts for program operations including contracts and other purchasing. //2014//

Form 4 (Budget Details by Type of Individuals Served) and Form 5 (State Title V Programs Budget and Expenditures by Type of Services)
Rhode Island has continued to be successful for FY 09 expended funds in meeting the budget requirements of at least 30% of our federal MCH funds was utilized for Preventive and Primary

Care for Children (30%) and at least 30% for Children with Special Health Care Needs (41%). The proportion of federal MCH funds expended for FY09 is 9.5%, which is under the allowable 10%.
/2012/ Rhode Island has continued to be successful for FY 10 expended funds in meeting the budget requirements of at least 30% of our federal MCH funds was utilized for Preventive and Primary Care for Children (30%) and at least 30% for Children with Special Health Care Needs (44.8%). The proportion of federal MCH funds expended for FY09 is 9.3%, which is under the allowable 10%.//2012//
/2013/ Rhode Island has continued to be successful for FY 11 expended funds in meeting the budget requirements of at least 30% of our federal MCH funds was utilized for Preventive and Primary Care for Children (33.5%) and at least 30% for Children with Special Health Care Needs (39.1%). The proportion of federal MCH funds expended for administration is 7.2%, which is under the allowable 10%.//2013//

/2014/ Rhode Island has continued to be successful for FY 12 expended funds in meeting the budget requirements of at least 30% of our federal MCH funds were utilized for Preventive and Primary Care for Children (33.6%) and at least 30% for Children with Special Health Care Needs (41.1%). The proportion of federal MCH funds expended for administration is 7.9%, which is under the allowable 10%.//2014//

Both forms represent an overall decrease in state partnership spending and variances for distributions of funding among the MCH populations and services types due to a couple of reasons. The state funding included in the State Partnership was subject to state budget reductions. Secondly, the FY09 expended reflects variances among with disbursement of funds for MCH populations compared to the FY09 budgeted. For Pregnant Women, Children 1 to 22 years of age and Children with Special Health Care Needs, the HIV treatment, smoking cessation and tobacco prevention all reflect shifts in the disbursement of funds for these populations. As for type of services, the reason for the variance in type direct service is that for the FY09 budget, the HIV treatment program was reflected to be a portion provided under direct service for type of service and for the FY09 expended, HIV is 100% direct service. The shift in HIV expenditures also impacts the variance for enabling services and infrastructure services. In addition to the variance in HIV, the childhood and adult immunization budget funding also impacted the variance for infrastructure building services for FY09 expended. A portion of immunizations expenditures were not included in the FY09 budget as infrastructure services, but is in the FY09 expended. While there is an apparent variance in infrastructure, it is not as apparent for population based services. While the HIV expenditures varied from the FY09 budget, the shift is obvious since the immunization FY09 budget funds shifted to population based services in FY 09 expended.
/2012/Form 4 and Form 5 present a decrease in state partnership spending due to budget reductions and a decrease in spending compared to the SFY10 budget. Reductions include program areas related to HIV and Worksite Wellness. FY10 spending for Newborn Screening, Child and Adult Immunization were decreased compared to the FY10 budget projection and restricted funds were rolled over to the next year.
The FY10 expenditures reflect variances among with disbursement of funds for MCH populations compared to the FY10 budgeted. The two significant variances are with Children 1 to 22 years of age and the "Others" populations. The difference for the variances is due to the shift of the Child Immunization program appropriately reflected under Children 1 to 22 years of age in the FY10 expenditure column compared to being reflected under the "Others" column in the FY10 budget. //2012//
/2013/Form 4 and Form 5 present a decrease in state partnership spending due to revenue reductions in newborn screening and childhood immunization restricted funding compared to the SFY11 budget. Revenue is based on the number of births for newborn screening and the health insurance assessment rates for childhood immunization. The FY11 expenditures reflect variances among with disbursement of funds for MCH populations compared to the FY11 budgeted due to the overall decrease in expenditures compared to the FY11 budget. One variance increase is with the "Other" population which reflects an increase in the adult childhood restricted account due to the purchasing of two additional adult vaccines. //2013//

/2014/ Form 4 and Form 5 present a decrease in state partnership spending due to revenue reductions in newborn screening and state funding reductions. However, the childhood immunization restricted funding increased and therefore does not reflect a larger variance of 2012 expended compared to the amount budgeted. //2014//

An attachment is included in this section. VA - Expenditures

B. Budget

/2011/ Budget Narrative
In FY2011, the Division proposes to spend $1,770,159 including an estimated carry forward of $1,093,295 from FY2010. Our Office of Children with Special Health Care Needs will continue to expand and address the needs of vulnerable young children and adolescent, investing in parent involvement and system building during FY11. Community, Family Health and Equity (CFHE) continues to focus on the rising birth rate, children's mental health, adolescent health/teen pregnancy prevention, and early childhood investments. CFHE 2011 budget allocates $1,770,159, of which 36.5% ($646,975) will be expended on children with special care needs, 33.3% ($589,943) will be expended on preventive services for children and 5.91% ($104,561) was allocated for administrative cost. The Division's budget for FY2011 presents a decrease in funding with a budget of $65,643,219 (not including $1,773,489 of state Medicaid match funds) due to only one quarter of the WIC program funding included in the FY11 enacted budget since the program is expected to transfer to Office of Health & Human Services beginning Oct 1, 2010. In addition to the transfer WIC, CFHE has received seven new federal ARRA grants to be included in FY11 and also the addition of CNOM HIV and Women's Cancer Screening funding.

/2012/ Budget Narrative
In FY2012, the Division proposes to spend $1,770,159 including an estimated carry forward of $1,014,131 from FY2011. Our Office of Children with Special Health Care Needs will continue to expand and address the needs of vulnerable young children and adolescent, investing in parent involvement and system building during FY12. Community, Family Health and Equity (CFHE) continues to focus on the rising birth rate, children's mental health, adolescent health/teen pregnancy prevention, and early childhood investments. CFHE 2012 budget allocates $1,770,159, of which 37% ($666,526) will be expended on children with special care needs, 34% ($588,457) will be expended on preventive services for children and 7% ($91,936) will be expended for administrative cost. The Division's budget for FY2012 represents a increase in funding with a budget of $96,245,819 due to the WIC program funding restored at the full level in the Governor's recommended FY12 budget since the program did not transfer to Office of Health & Human Services on Oct 1, 2010. In addition to the WIC funding being restored, CFHE has received nine federal ARRA grants and projected expenditures were included in the FY12 budget along with HIV and Women's Cancer Screening Cost Not Otherwise Matched (CNOM) federal share matching.//2012//

/2013/ Budget Narrative
In FY2013, the Division proposes to spend $1,725,040 including an estimated carry forward of $528,230 from FY2012. Our Office of Children with Special Health Care Needs will continue to expand and address the needs of vulnerable young children and adolescent, investing in parent involvement and system building during FY13. Community, Family Health and Equity (CFHE) continues to focus on the rising birth rate, children's mental health, adolescent health/teen pregnancy prevention, and early childhood investments.

CFHE 2012 budget allocates $1,725,040, of which 37.07% ($639,472) will be expended on children with special care needs, 35.11% ($605,661) will be expended on preventive services for children and 9.92% ($171,124) will be expended for administrative costs. The Division's budget for FY2013 represents a decrease in funding with a budget of $68,033,795 due to the WIC

program transfer to the Department of Human Services (DHS) in the enacted FY13 budget. However, WIC staffing and day to day programmatic and administrative functions currently remain at Health. Health has access to the WIC accounts under DHS budget and continues to process contracts and other purchases. In addition to the transfer of WIC funding, out of the nine federal ARRA grants CFHE received, three grants have closed out in SFY12 and four grants have ended and are expected to close out in SFY13.

CFHE has received new federal funding under the Affordable Care Act for Home Visiting and Coordinated Chronic Disease and Prevention. In addition, CFHE recently received new federal grants to fund initiatives for disabilities, arthritis and immunization vaccine management system. //2013//

CFHE 2012 budget allocates $1,725,040, of which 37.07% ($639,472) will be expended on children with special care needs, 35.11% ($605,661) will be expended on preventive services for children and 9.92% ($171,124) will be expended for administrative costs. The Division's budget for FY2013 represents a decrease in funding with a budget of $68,033,795 due to the WIC program transfer to the Department of Human Services (DHS) in the enacted FY13 budget. However, WIC staffing and day to day programmatic and administrative functions currently remain at Health. Health has access to the WIC accounts under DHS budget and continues to process contracts and other purchases. In addition to the transfer of WIC funding, out of the nine federal ARRA grants CFHE received, three grants have closed out in SFY12 and four grants have ended and are expected to close out in SFY13.

CFHE has received new federal funding under the Affordable Care Act for Home Visiting and Coordinated Chronic Disease and Prevention. In addition, CFHE recently received new federal grants to fund initiatives for disabilities, arthritis and immunization vaccine management system. //2013//

Our Maternal and Child Health investment for FY2009 was $79,858,168 including $6,706,155 of state and restricted newborn screening funding, excluding program income and private funds.

/2012/ Our Maternal and Child Health investment for FY2012 is $96,245,819 including $4,385,647 of state and restricted newborn screening funding, excluding program income and private funds.//2012//

/2013/ Our Maternal and Child Health investment for FY2013 is $68,033,795 including $3,452,037 of state and restricted newborn screening funding, excluding program income and private funds. Funding is reduced compared to prior years due to the transfer of the HIV treatment state funding to Office of Health & Human Services (OHHS) in the enacted 13 budget. The Office of Health & Human Services is the umbrella agency in which Health is one of the state agencies under OHHS. (FY12's budget was submitted based on the SFY12 Governor's recommended budget. The enacted SFY12 year budget transferred the HIV Care program to DHS and the enacted SFY13 budget transferred the HIV Care program from DHS to OHHS. //2013//

The maintenance of effort amount for FY2009 and for proposed FY2011 exceeds the FY89 level of effort of $1,875,000. Our commitment to Kids Net, Parent Consultants, Newborn Screening, and Adolescent Health are some of the ways that RI commits state funds to maintain its match with HRSA, Title V. Rhode Island defines administrative costs as those costs associated with disbursing funds from a central office (e.g., budgeting, oversight) that fall within the purview of administration. This is consistent with a legal opinion on the subject obtained by the Association of Maternal and Child Health Programs.

/2012/ The maintenance of effort amount for FY2010 and for proposed FY2012 exceeds the FY89 level of effort of $1,875,000. Our commitment to Kids Net, Parent Consultants, Newborn Screening, and Adolescent Health are some of the ways that RI commits state funds to maintain its match with HRSA, Title V. Rhode Island defines administrative costs as those costs associated with disbursing funds from a central office (e.g., budgeting, oversight) that fall within

the purview of administration. This is consistent with a legal opinion on the subject obtained by the Association of Maternal and Child Health Programs.//2012// /2013/ The proposed maintenance of effort for FY13 exceeds the FY89 level of effort of $1,875,000. //2013//

Rhode Island proposes to expend approximately $5,473,357 of the total state resources from all sources (including program income and private funds) on core public health/infrastructure activities. RI proposed to expend $17,538,872 on population based services which is consistent to the amount proposed for FY10. The proposed amount of $539,835 for direct health care services is a 73% decrease from the previous year (FY10: $1,996,609) due to a reduction in the overall budget from FY10 of $26,153,082 to FY11 of $24,191,941 while continuing to maintain consistency in the types of services categories for FY11 compared to FY10.

/2012/ Rhode Island proposes to expend approximately $5,589,431 of the total state resources from all sources (including program income and private funds) on core public health/infrastructure activities. RI proposed to expend $17,587,735 on population based services which is consistent to the amount proposed for FY11. The proposed budget amount for enabling services is $657,325 and for direct health care services is $438,002. For direct services, the proposed budget is an estimated 20% decrease from the previous year (FY11: $539,835).//2012//

/2013/ Rhode Island proposes to expend approximately $5,208,191 of the total state resources from all sources (including program income and private funds) on core public health/infrastructure activities. RI proposed to expend $19,796,746 on population based services which is slightly higher than the amount proposed for FY12. The proposed budget amount for enabling services is $323,699, which is slightly less than 50% of the amount proposed in FY12. The reduction of enabling services reflects a shift to population based services. For direct health care services the proposed FY13 budget is slightly less than one-fourth the proposed FY12 budget ($99,495) reflecting the shift of direct services to population based services.//2013//

The Division's Executive Office guides the process of assuring that funded MCH grant projects are aligned with the MCH priorities. The Division's Title V Maternal and Child Health Block Grant uses a life course development approach in addressing the social determinants of health as a framework for health planning.

The Division plans to allocate its FY2011 award to meet the goals outlined in the annual plan by purchasing services from and contracting with other state agencies and community-based providers using standard purchasing procedures including RFPs, and sole/single source provider justifications. Every contract is managed by a Team Lead or program manager, as well as monitored by fiscal staff. Payment for services outlined in the contract is reviewed and approved by the contract officer and the division Chief Program Operations prior to reimbursement. //2011//

/2012/ The Division plans to allocate its FY2012 award to meet the goals outlined in the annual plan by purchasing services from and contracting with other state agencies and community-based providers using standard purchasing procedures including RFPs, and sole/single source provider justifications. Every contract is managed by a Team Lead or program manager, as well as monitored by fiscal staff. Payment for services outlined in the contract is reviewed and approved by the contract officer and the division Operations Administrator prior to reimbursement.//2012// /2013/ In FY13, operations will continue to monitor the expenditures monthly and on a quarterly basis coordinate with the Team Lead or Project Manager on the project budget projections.//2013//

/2014/ Budget Narrative
The FY 14 total Partnership budget is made up of $2,068,445 (including carry forward funds) and $2,008,389 in state funds. CFHE continues to budget at least 30% of out federal MCH funds for preventative services for children (37.53%) and for children with special health care needs (35.28%). The administrative cost is under the allowable 10% cap

(9.27%). CFHE maintenance of effort continues to exceed the required 1989 amount of $1,875,000 with efforts over $27M.

The overall Partnership budget has increased for FY14 as a result of program income. Revenue for child and adult immunizations has increased in addition to securing loan repayment donation funding. However, federal MCH Block grant funds have decreased over the past several years. States recently received the FY 13 funding allocation and Rhode Island received a 9.92% reduction from GY 12 and compared to GY11, a 11.01% reduction. In addition to the loss of MCH federal funds, state funding also has continued to decrease over the past budget years. For the SFY14 budget, MCH state funding has reduced due to the retirement and elimination of the Block Island community nurse FTE position. Newborn screening funding has slightly increased which conceals the loss of the MCH funding. As a result, the overall impact is less than the cost of the full FTE.

The FY14 Other Federal funds of $36,924,037 comes from 47 different grants and three administrative Medicaid accounts. CFHE continues to look for opportunities to integrate and collaborate with existing grants and with new grant opportunities for programmatic areas under CFHE. The federal funding has decreased over the last couple of years as previously mentioned in past applications. For SFY14, ARRA funding has also been excluded due to temporary funding limitations on the grants CFHE received.

Rhode Island proposes to expend approximately $6,020,846 of the total state resources from all sources (including program income and private funds) on core public health/infrastructure activities. RI proposes to expend $23,394,597 on population based services. The proposed budget amount for enabling services is $405,825 and for direct health care services, it is $108,993. When comparing the percentages to the total partnership amount, the percentages are relatively the same for FY14 compared to FY13. Direct service is less than 1%, enabling services is slightly more than 1%, infrastructure building services has remained at 20% and population-based services has remained at 78%.

In FY14, operations will continue to monitor the expenditures monthly and on a quarterly basis coordinate with the Team Lead or Project Manager on the project budget projections. //2014//

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

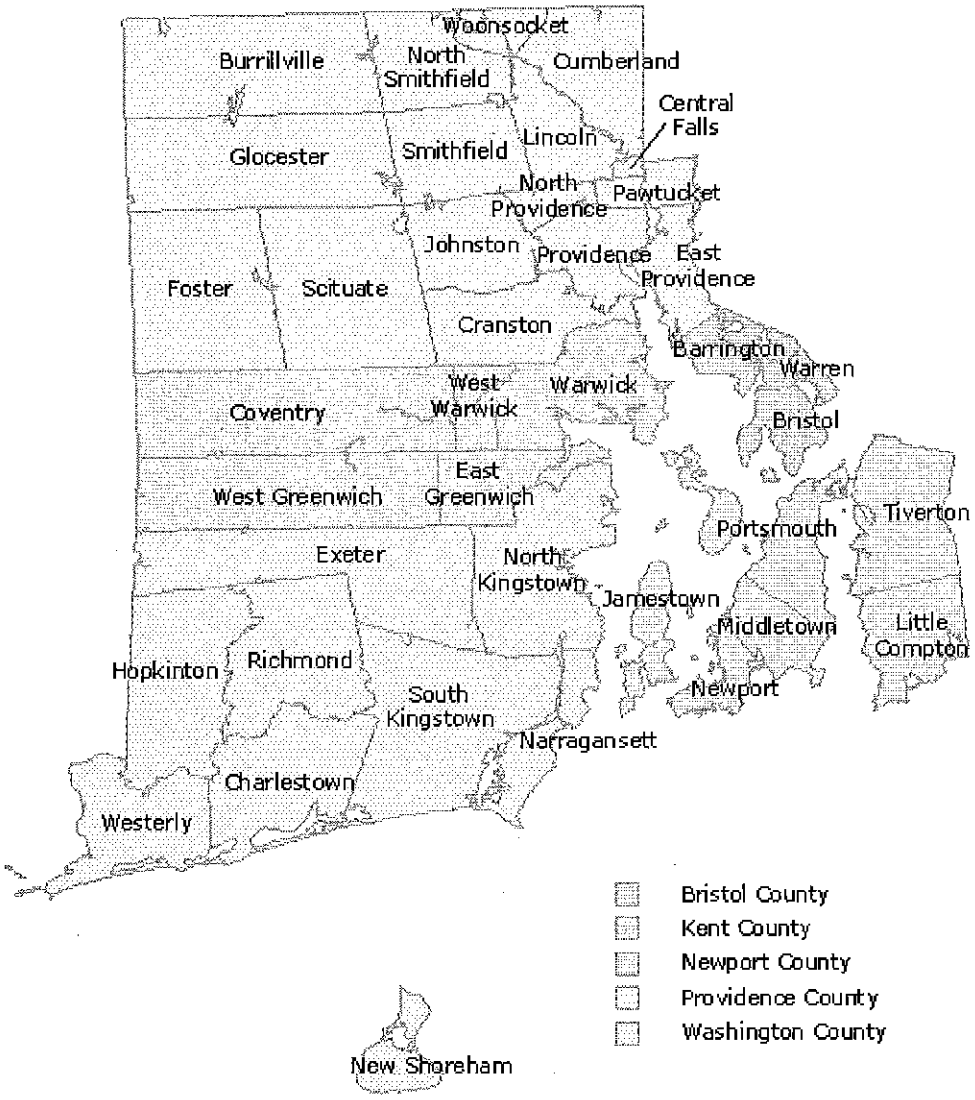
D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.

Attachment I
Rhode Island Department of Health
Areas Affected By The Project-FY2014

Map of Rhode Island Counties, Cities, and Towns

The Entire State is Affected by the Project



Counties	Cities	Towns	
Bristol County	Central Falls	Barrington	Narragansett
Kent County	Cranston	Bristol	New Shoreham
Newport County	East Providence	Burrillville	North Kingstown
Providence County	Newport	Charlestown	North Providence
Washington County	Pawtucket	Coventry	North Smithfield

Providence
Warwick
Woonsocket

Cumberland
East Greenwich
Exeter
Foster
Glocester
Hopkinton
Jamestown
Johnston
Lincoln
Little Compton
Middletown

Portsmouth
Richmond
Scituate
Smithfield
South Kingstown
Tiverton
Warren
West Greenwich
West Warwick
Westerly

RHODE ISLAND DEPARTMENT OF HEALTH

Notice of Community Input Session

Maternal & Child Health Services Block Grant Application (FY-2014)

In accordance with grant requirements, the Rhode Island Department of Health will hold a community input session to facilitate comment from any person during the development of the state plan for the ***Maternal & Child Health Services Block Grant Application (FY-2014)***. Any person who wishes to offer comments on this issue may appear and provide it. The community input session will be conducted on:

THURSDAY, JUNE 27, 2013 AT 11:00 A.M.
in the AUDITORIUM of the Cannon Building (lower level)
Rhode Island Department of Health
Three Capitol Hill
Providence, RI 02908

Written comments may also be submitted prior to the date of the community input session to Cheryl LeClair, Rhode Island Department of Health, Room 302, 3 Capitol Hill, Providence, RI 02908 or via e-mail: **cheryl.leclair@health.ri.gov**. Or, persons may provide input through the following survey monkey link:
https://www.surveymonkey.com/s/2013MCHsurvey

The Department of Health is accessible to the handicapped. If communication assistance (readers/interpreters/captioners) is needed, or any other accommodation to ensure equal participation, please call 401-222-7767 or RI Relay 711 at least three (3) business days prior to the meeting so arrangements can be made to provide such assistance at no cost to the person requesting.

Signed this 13th day of June 2013

Ana Novais, MA, Executive Director of Health
Division of Community, Family Health and Equity
Rhode Island Department of Health

Department of Health

Three Capitol Hill
Providence, RI 02908-5097

TTY: 711
www.health.ri.gov

Division of Community, Family Health, & Equity
Maternal & Child Health Program
Block Grant Community Input

The Division of Community, Family Health, & Equity (DCFHE) is interested in your input to the next Maternal and Child Health Plan. Please take a few minutes to give feedback on the existing state priority areas. Keep in mind that the DCFHE uses a life course development approach that addresses the determinants of health as its framework for health planning.

Please comment on the **critical action steps, interventions, or policies** you see as necessary to address the *2010 – 2015 Maternal and Child Health State Priorities.*

1. **Increase access and capacity to evidence based parent education and family support programs.** Empowered parents can assess their child's development and advocate for needed services, as well as work to change the context of health choices as the default option within individual home and in community-based settings that serve children and their families.

2. **Reduce tobacco initiation among middle school students.** Strategic policy development can eliminate access to tobacco for minors. Additionally, population based services like health education can inform youth about tobacco and create environments where healthy choices are the default choice. Direct healthcare services (e.g. tobacco cessation services) and education and counseling could include the development of evidence-based approaches to support youth who have initiated tobacco use already.

3. **Increase the percentage of insured adolescents who have a preventive "well care" visit each year.** Increasing the number of adolescents receiving well child visits needs to be considered to develop supportive systems of care for adolescents thereby addressing social determinants of health (e.g. housing, education, inequalities, etc.).

4. **Increase the social and emotional health of children and youth with special health care needs** through infrastructure building services. These include well-integrated academic interventions; enabling services such as positive social and recreational activities; population- and individually based education and counseling programs that support self-determination and student leadership; and direct healthcare interventions that address behavioral health concerns.

5. **Increase the percentage of women who had a preventive care visit in the last year.** Increasing the percentage of women who had a preventive healthcare visit in the previous year is expected to improve health outcomes for women, including those related to preconception health and chronic disease prevention.

6. **Initiate a prenatal home visiting program.** Home visitors provide general parenting information, conduct home assessments, educate parents about infant care, and link families to appropriate services and resources.

7. **Adopt the social determinants of health into public health practice.** This priority is overarching across all maternal and child health populations. It reflects the importance of addressing risks and protective factors that influence healthy development across the lifespan.

8. **Other comments.**

Date: CY2012

ATTACHMENT III- Public Input Summary
FY 2014 RHODE ISLAND TITLE V MCH BLOCK GRANT

Priority #1 (Early Childhood): Increase access and capacity to evidence-based parent education and family support programs. Empowered parents can assess their child's development and advocate for needed services, as well as work to change the context of health choices as the default option within individual home and in community-based settings that serve children and their families. What critical action steps, interventions, or policies do you see as necessary to address this priority?

Summary of Community Input: In order to increase access and capacity to evidence-based parent education services in Rhode Island, the Title V Program should focus on building systems and implementing programs that ensure coordination of care, help with systems navigation, family focused times and locations for services, offer peer to peer support and increase evaluation of existing programs and parent engagement strategies. HEALTH and partners should focus on creating consistency among state funded parent education programs, creating partnerships with employers to help parents participate in their children's lives in school and after school, creating new ways to provide families with access to information (i.e. face to face intervention and materials available in different languages), linkage of parent outreach activities to coordinated early childhood and school based programs, collaboration with schools, cultural competency, enabling services (i.e. child care, parent support, transportation), evidence-based services, standards for parent education and services curricula, and increasing in the number of quality parent education and support programs in Rhode Island. Also, work is needed to continue the development of an effective collaborative process to establish a clear infrastructure that integrates resources to ensure that at risk families receive appropriate education and support.

Rhode Island Title V Program's Response: Utilizing federal Maternal, Infant and early Childhood (MIECHV) and other funds, HEALTH is working to build a statewide system that ensures linkage and coordination of all evidence-based parent education and support programs in the state, which includes home visiting and other evidence-based programs such as the Incredible Years parent education program and promising practices, such as the OSHCN's Pediatric Practice Enhancement Project (PPEP). Through the establishment of a Home Visiting Leadership Council (HVLC), Local Implementation Teams (LITs), Community Coalitions, and a Home Visiting Network, HEALTH will focus initially on ensuring that the systems of supports for MCH home visiting is strong. This system will then be broadened to focus on including and supporting a framework for evidence-based parent education programs that are not MCH home visiting-based. Through these efforts, a coordinated referral process for pregnant women and strong linkages with WIC services and OB/GYN and pediatric providers is in the process of being established. HEALTH will also participate on a newly mandated Family Engagement Council and other relevant advisory bodies. HEALTH's goal is to create a system that offers services along a continuum of need in which all families are able to take advantage of services for which they are eligible and that these services do not duplicate efforts but maximize resources.

Also, HEALTH continues to work with DCYF and RIDE to continue development of an effective collaborative process to establish a clear infrastructure that integrates resources from HEALTH, RIDE, and DCYF to ensure that at risk families receive appropriate education and support.

Priority # 2 (Middle Childhood): Reduce tobacco initiation among middle school students. Strategic policy development can eliminate access to tobacco for minors. Additionally, population-based services like health education can inform youth about tobacco and create environments where healthy choices are the default choice. Direct healthcare services (i.e. tobacco cessation services) and education and counseling could conclude the development of evidence-based approaches to support youth who have initiated tobacco use already. What critical action steps, interventions, or policies do you see as necessary to address this priority?

Summary of Community Input: In order to reduce initiation among middle school students in Rhode Island, the Title V Program should focus on building systems and implementing programs that ensure partnerships with schools and communities to develop tobacco awareness programs as a part of the mandated health curriculum, funding programs that promote healthy habits and stress management skills (i.e. sports, music, art, dance etc.), children who do not smoke are receiving recognition in the community for not smoking, public awareness to avoiding peer pressure to smoke, having peer learning and role models in schools, providing trips to nursing homes to see the results of lung cancer from smoking, easy assess to smoking cessation services for children who smoke, law enforcement (passing laws against parents smoking in a vehicle with a minor, preventing them from getting their license if get caught smoking), raising prices on cigarette taxes, commercials (i.e. how dangerous smoking is), campaigns (i.e. against stores who sells to minors, prevention of vendors from selling tobacco and nicotine products), interventions for parents who use tobacco, youth development opportunities, and implementation of strategies used by tobacco companies in a positive way.

Rhode Island Title V Program's Responses: HEALTH takes a comprehensive approach to reducing tobacco initiation among middle school students. Input from the Rhode Island Tobacco Control Network, representing cross-sector organizations and individual stakeholders, helps the Tobacco Control Program (TCP) set its youth priorities and prevention strategies. The TCP also works with communities to collect and share empirical data impacting sub-populations of youth to demonstrate inequities, inform development of effective plans, and assure direction of efforts to areas of greatest health impact. Data collection includes neighborhood observational assessment, door to door surveys, focus groups, risk factor surveillance, and other research. The TCP informs stakeholders regarding evaluation, data, and best practice to help communities set priorities and youth development activities.

Priority # 3 (Adolescence): Increase the percentage of insured adolescents who have a preventive "well care" visit each year. Increasing the number of adolescents receiving well child visits needs to be considered to develop supportive systems of care for

adolescents thereby addressing social determinants of health (i.e. housing, education, inequalities, etc.) What critical action steps, interventions, or policies do you see as necessary to address this priority?

Summary of Community Input: In order to increase the percentage of insured adolescents who have a preventive "well care" visit each year in Rhode Island, the Title V Program should focus on building systems and implementing programs that ensure guidance for physicians serving adolescence, time and location of services that are family-focused (i.e. weekend/ evening), messages about the importance of well care visits are integrated in school health curricula, family planning services, teen to teen approach (i.e. work with teens to create messages to their peers, older teen talking to younger teens), evaluation on adolescent use of care, incentives for patients and providers (i.e. keeping appointments and for pediatrics practices to do reminder calls to schedule appointments), physical examinations as a requirement for school entry, outreach to engage families, campaign (i.e. kids talking to kids about the benefits of visits and how frequently they should go), and transportation for teens and parents to access care.

Rhode Island Title V Program's Responses: Visionary and collaborative approaches can help ensure successful medical home models for adolescence to address their developmental needs. Research was conducted to better understand how adolescents access medical services. A report was developed including four distinct components. The first is the introduction and literature review. The second is a summary of recommendations for improving adolescent access from the American Academy of Pediatrics, Institute of Medicine and the Society of Adolescent Medicine. The third is a qualitative study commissioned by HEALTH in partnership with Brown University. Jane Griffin of MCH evaluation conducted the research. The fourth component, also commissioned by HEALTH, in partnership with John Snow Institute, is a needs assessment and data analysis of a broad range of adolescent health concerns that is a part of Rhode Island Title V MCH Comprehensive Needs Assessment. This work was supported with funding from the Title V MCH Block Grant. Recommendations to improve adolescent access to care include:

Access to Care

- Engage and support providers in quality improvement for medical homes including transition processes.
- Require a physical exam for all Rhode Island high school students linked to the last required dose in the meningococcal vaccine.
- Ensure comprehensive consent and confidentiality laws to support access to care.
- Advocate for laws that allow minor's to consent to their own care.
- Develop family community partnerships for prevention and community based services including physical and reproductive; behavioral; and oral health care.
- Invest in analysis of where adolescents are getting their and barriers to care.
- Plan for youth transitioning out of foster care; begin transition planning for all youth including those with special health care needs in middle school.
- Strengthen relationships among school and community providers related to physical and behavioral health services.

Access to Insurance

- Promote health insurance coverage which includes a comprehensive and coordinated benefits package.
- Identify gaps in insurance coverage.
- Advocate for policies and legislation that supports insurers in providing comprehensive and confidential access to care for adolescents.
- Balance high cost treatment investments with prevention focused community investments in work of Health Insurance Commissioner.

Quality Assurance

- Identify HEDIS measures that support adolescent health such as preventive care, immunization schedule completion, and percent of sexually active teens with Chlamydia test.
- Identify additional measures of adolescent health via HEDIS, KIDSCOUNT and other data sources.
- Create a learning collaborative for providers, starting with a toolkit.
- Develop toolkit based on a condensed version of Bright Futures.
- Develop a similar kit for youth and parents HEALTH transition resources.

Systems Development

- Bring together providers interested in adolescent health.
- Develop curriculum around adolescent health for use with providers and physician residents interested in developing expertise around adolescent health concerns.
- Expand the Ask a Doc website to answer youth health related questions in a timely fashion.
- Link with DCYF system of care.
- Investigate BCBS and UHC performance benchmarks (adolescent health care visits).
- Expand performance base as tools to focus attention on adolescent health concerns.
- Ensure a voice for adolescents at health care reform discussions, programs and policies.
- Cultivate youth development approaches in schools and communities.
- Support efforts to improve health education in school and community settings.
- Explore strategies to increase peer education efforts.
- Evaluation on adolescent use of care funded to inform systems related to health care reform.

Stakeholders in Rhode Island are also considering advocating for a primary care visit as a requirement for 9th and 10th grade school entry. Currently, the last school-required health visit is for 7th grade.

Priority # 4: Increase the social and emotional health of children and youth with special health care needs Strategies that improve access to services such as well-integrated academic interventions; positive social and recreational activities; population and individual based education and counseling programs that support self-determination and student leadership; and direct health care interventions that address behavioral health concerns. What critical action steps, interventions, or policies do you see as necessary to address this priority?

Summary of Community Input: In order to increase the social and emotional health of CYSHCN through infrastructure-building services in Rhode Island, the Title V Program should focus on building systems and implementing programs that ensure adequate funding and capacity (i.e. extend the school/ work day), support for existing successful youth development and leadership programs (i.e. Dare to Dream conference), extracurricular opportunities (i.e. Special Olympics, youth programs, choirs, after school programs, sports etc.), comprehensive mental health services at the school level, parent involvement and commitment, family support, increase access and linkage (i.e. screening results/ early detection methods to available targeted intervention and behavioral health services), and transportation for children and parents to access programs.

Rhode Island Title V Program's Responses: Based on community input, Title V CYSHCN funds have been allocated to support 1) the Pediatric Practice Enhancement Project (PPEP) which enhances the medical home for CYSHCN through parent – professional partnerships and 2) the Dare to Dream Initiative which promotes positive youth development opportunities for YSHCN and their families. The OSHCN works across programs to ensure the full inclusion of CYSHCN in DCFHE health promotion and wellness programs, specifically the initiatives addressing middle school smoking initiation. OSHCN staff will also continue to explore grass-route family engagement strategies such as Home School Liaisons in Central Falls, Parent Academy in Westerly, and Family Engagement Office in Providence. The OSHCN will support the infrastructure and further incorporate a parent professional partnership model in addressing family involvement, child outcomes and achieving post-school goals.

The OSHCN continues to build the Dare to Dream initiative to include additional community stakeholders, organizations, juvenile justice, schools, and natural partners in youth development. The advent of Youth Health Coaches as a new program of the OSHCN is a direct response to community input and disparity data for youth with special needs. The OSHCN intends to expand health promotion and wellness offerings to YSHCN who tend to participate in more risk behaviors and have poorer health outcomes than their peers.

Priority # 5 (Women across the Lifespan): Increase the percentage of women who had a preventive care visit in the last year. Increasing the percentage of women who had a preventive health care visit in the previous year is expected to improve health outcomes for women, including preconception health and chronic disease prevention. What critical action steps, interventions, or policies do you see as necessary to address this priority?

Summary of Community Input: In order to increase the percentage of women who had a preventive care visit in the last year in Rhode Island, the Title V Program should focus on building systems and implementing programs that ensure outreach and education, accessible resources (i.e. making sure women have insurance, access low cost health care). Efforts to expand access to patient-centered medical homes (i.e. transportation and making the process of getting RIte Care or other state insurance easier) should target primary care providers at underserved areas serving largely female populations (i.e. low-income populations and assessing community needs). State agencies should coordinate efforts to inform providers and consumers of the newly covered.

Rhode Island Title V Program's Responses: Building on national opportunities, resources, and previous Department initiatives to address women's health, HEALTH embarked on developing a strategic plan to identify and prioritize the preconception health needs of Rhode Island. Through funding made possible by the federal Title V MCH Block Grant, HEALTH coordinated this statewide effort. Preconception health, the health of an individual during pre-pregnancy periods, encompasses a variety of strategies implemented across a range of health and social service settings to improve overall health and maximize healthy pregnancies. Although interventions tend to focus on women, these preconception health opportunities are important to both women and men across the life course regardless of reproductive age or pregnancy intention. Providing a continuum of care and preventive interventions across the life course ensures that health is addressed at different life stages as well as during critical and sensitive periods, such as adolescence and the perinatal (around childbirth) and postpartum periods. This approach improves not only the future well-being of the individual but also the health of future generations. Strategies include clinical, public health, and policy and finance solutions, all of which minimize disparities in preconception risk factors and reduce broader social, racial, and economic inequalities in health. Through development of the strategic plan a newly formed Preconception Health Collaborative was formed. The Collaborative is committed to refining and carrying this plan through implementation to ultimately improve the health of all Rhode Islanders.

In addition, HEALTH will maintain an active collaborative partnership with the Primary Care Association (PCA), the Rhode Island Area Health Education Centers Network (AHEC), and other appropriate entities, including AAP/CATCH, to provide technical assistance to communities and organizations interested in expanding access to care for the underserved, including women. HEALTH will participate on the CSI-RI All Payer Medical Home Demonstration Project Advisory Committee, Beacon Advisory Committee, and AHEC Advisory Committee in order to leverage primary care investments, maintain awareness of primary care initiatives, and provide the public health perspective and expertise to primary care professional audiences. HEALTH will also work to implement primary care, patient centered medical home public reporting measures.

Priority #6 (Pregnant Women): Initiate a prenatal home visiting program. Home visitors provide general parenting information, conduct home assessments, educate parents about infant care, and link families to appropriate services and resources. What critical action steps, interventions, or policies do you see as necessary to address this priority?

Summary of Community Input: In order to initiate a prenatal home visiting program in Rhode Island, the Title V Program should focus on building systems and implementing programs that ensure linkage and coordination of all home visiting programs, referral processes that begin at the first prenatal visit and while infant is still in the hospital, connection of prenatal home visiting programs with WIC, reimbursement for nurse home visitors, education and outreach (i.e. providing community classes for people thinking about having children, materials offer in a different language), targeting of specific businesses for promotion (i.e. hair salons, grocery stores, Laundromat, baby stores etc.) use of OB/GYN providers and other providers for referrals (i.e. consider one main number for the community to call to receive appropriate services), coordination among all home visiting programs, and incentives for both the referrer and patients.

Rhode Island Title V Program's Responses: Utilizing federal MIECHV funds, the Title V Program's Home Visiting Program is working to build a statewide system that ensures linkage and coordination of all home visiting programs in the state (not just those that are MIECHV-funded) through the establishment of a Home Visiting Leadership Council (HVLC), Local Implementation Teams (LITs), and a Home Visiting Network. Through these efforts, a coordinated referral process for pregnant women and strong linkages with WIC services and OB/GYN and pediatric providers is in the process of being established.

Priority # 7 (overarching Priorities): Adopt the determinants of health into public health practice. This priority is overarching across all MCH populations and reflects a life course perspective while addressing the social determinants of health (i.e. address risks and protective factors that influence healthy development across the lifespan). What critical action steps, interventions, or policies do you see as necessary to address this priority?

Summary of Community Input: In order to adopt the social determinants of health into public health practice in Rhode Island, the Title V Program should focus on building systems and implementing programs that ensure equitable treatment and coordination in all levels. HEALTH should collaborate with other state agencies to develop more programs that involve more family activities (health literacy, budgeting, nutrition, physical activities, family events etc.) to reduce the effects of social determinants of health.

Rhode Island Title V Program's Responses: The social determinants of health encompass a wide range of factors that impact individual, family, and/or community's health. These can include economic status, location of residence, education level, etc. The Rhode Island General Assembly passed a law in 2011 establishing the Commission for

Health Advocacy and Equity. The purpose of the Commission is to develop and facilitate coordination of the expertise and experience of the state's health and human services, housing, transportation, education, environment, community development, and labor systems in developing comprehensive health equity plan addressing the social determinants of health. The Commission was designed to provide direct advice to the Director of HEALTH, and indirect advice to other state department's senior administrators and planners, regarding issues of racial, ethnic, cultural, or socio-economic health disparities. Specifically, the purpose of the Commission for Health Advocacy and Equity is to:

- Advocate for the integration of all relevant activities of the state to achieve health equity;
- Provide advice to the Director of Health and the Department's senior administrators regarding issues of racial, ethnic, cultural, or socio-economic health disparities;
- Develop and facilitate coordination of the expertise and experience of the state's health and human services, housing, transportation, education, environment, community development, and labor systems in developing a comprehensive health equity plan addressing the social determinants of health;
- Set goals for health equity and prepare a plan for Rhode Island to achieve health equity in alignment with any other statewide planning activities; and
- Educate state agencies in Rhode Island on disparities, including social factors that play a role in creating or maintaining disparities.

The commission will propose recommendations to address these issues, recommend a plan of action, and perform a bi-annual evaluation of state's efforts to reduce health disparities by addressing the social determinants of health. Further, HEALTH will use the Commission's input to inform MCH program and policy development.

Attachment IV: RI Department of Health Title V Needs Assessment Update – FY2014

The Rhode Island Department of Health (HEALTH) continues to monitor and assess, on an ongoing basis, its priority needs and capacity to meet goals and objectives defined in the State's comprehensive MCH needs assessment through a multi-pronged approach. The needs assessment process is one that relies on surveillance, parent and community input, and collaborations/partnerships.

Critically important to the success of Rhode Island's MCH program is the effective use of data to monitor, evaluate, and guide our programmatic activities. Utilizing data from Family Planning, Newborn Developmental Risk Screening and First Connections and the Maternal, Infant and Early Childhood Home Visiting program (Home Visiting) databases provide a current picture of the needs of pregnant women, infants, and their families. Additionally, the Pregnancy Risk Assessment Monitoring System (PRAMS) and Rhode Island's 2-year follow-up survey, the Toddler Wellness Overview Survey (TWOS), are additional tools to assess the experiences, behaviors, development, and/or well-being of these populations. Vital Records data allow us to track MCH indicators such as entry into prenatal care, low birth weight, and infant mortality.

Program databases such as WIC, Lead Screening, and Birth Defects provide information on children. Rhode Island's KIDSNET system is crucial in tracking data related to children's preventive services and for the determination of medical homes. Hospital discharge data, Youth Risk Behavior Survey (YRBS) and Information Works Survey [conducted by the RI Department of Education (RIDE)] are examples of tools used to assess the well-being of Rhode Island's youth. Additionally, the Behavioral Risk Factor Surveillance System (BRFSS) allows for detailed analyses for the adult population. Utilizing these data sources allows HEALTH to determine the trends and health status at different stages of the life course.

National surveys, such as the National Survey of Children with Special Health Care Needs (CSHCN), National Survey of Children's Health, and National Immunization Survey, provide state-level data on children including CSHCN. Our partnership with the Rhode Island Parent Information Network and Family Voices has led to the development and implementation of surveys and collection of data for families of CSHCN.

In addition, working closely with the other State agencies [e.g., Human Services (DHS); RIDE; and Children, Youth and Families (DCYF)], Rhode Island KIDS COUNT, March of Dimes, and other community organizations provides a more comprehensive understanding of the well-being of children and their families and the environment in which they live. State and local partnerships as exemplified through local Community Access to Child Health (CATCH) grants and initiatives with The Providence Plan have provided better information at a neighborhood level. Additionally, Rhode Island has started to conduct community health assessments to provide information about the impact of the built environment on health.

Finally, a key part of the needs assessment process is the involvement of parent consultants, families and communities. HEALTH's on-going MCH needs assessment relies heavily on parent/community input before, during, and after the Title V Application's for all MCH populations. Last year, HEALTH held an Adolescent Health Summit that identified systems issues to improve the health of adolescents as part of our targeted outreach to this population. Earlier this year, the Preconception Health Strategic Plan was shared with stakeholders leading to community input concerning the social and environmental contributors to unplanned pregnancy in RI.

At HEALTH, an MCH policy group representing the six priority populations and programmatic areas in RI tracks change in capacity, as well as any change in a population's strengths and needs with a goal of policy development. Any changes that appear in the on-going surveillance and analysis drive discussions, as well as various programmatic meetings with community partners and sub-contracts.

Below is a list of RI's state priorities, related performance measures, and the primary programmatic activities and initiatives undertaken to operationalize the 5-year needs assessment.

#	a. State Priority b. Performance Measure c. Data Review	Programmatic Activities Undertaken to Operationalize the 5-year Needs Assessment
1	a. Increase access and capacity to evidence based parent education and family support programs. b. **SPM 1:** Percent of RI resident families with at risk newborns that receive a home visit (HV) during the newborn period (<= 90 days). c. Between 2008 and 2011, the percentage of RI resident families with at-risk newborns that received a HV during the newborn period increased by 16%, from 45.0% to 52.0%, respectively. The capture rate for 2012 was 50.3%. This decrease may be due to some families that would have been seen by First Connections, but were instead picked up prenatally by the evidence-based home visiting programs	First Connections Home Visiting Program: • Contracts 4 community-based agencies to conduct HV to families of newborns at risk. • HV uses home visits to support families and their children during the early years of childhood development. Home visiting provides general parenting information and provides information to families on local and state evidence-based parent education and family support programs. • Community partners can refer older children (aged > 1) for HV services. • The ACA Maternal Infant and Early Childhood Home Visiting (MIECHV) Program has been implemented to expand evidence based home visiting services to low income, pregnant women under the age of 25. • Through MIECHV, HEALTH received funding to provide Healthy Families America and Nurse-Family Partnership® in Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket • HEALTH has received funding to provide Parents as Teachers in Central Falls, Pawtucket, Providence and Woonsocket. The evidence based home visiting programs funded through MIECHV will work with all other home visiting programs in those communities and statewide to provide comprehensive services to families most at risk for poor outcomes.
2	a. Reduce tobacco initiation among middle school students. b. **SPM 2**: Percent of middle school students who have initiated tobacco use. c. YRBS* data indicate that between 2009 and 2011, the percent of middle school students who initiated tobacco use decreased by 2.9%, from 17.0% to 16.5%, respectively. The 2012 performance goal is to reduce middle school tobacco initiation to 16.2%. HEALTH is currently working with multiple state and local partners towards meeting this goal and the recent decline in 2011 is encouraging. * Note: The YRBS is conducted every other year (odd years); the 2011 survey was the last available year of data. The 2013 YRBS was conducted this spring and weighted data are expected by early 2014.	CFHE's Health Promotion & Wellness Team: • Contracts with multiple partners working with community based organizations to reduce tobacco use & exposure for pregnant women & children. • Tobacco Control Program contracts with Quality Partners, Inc. & RI Health Center Association to promote tobacco cessation services. • Additionally, the NE Regional Chapter of the American Lung Association RI manages the Tobacco Control Network. • Home Visiting screens for tobacco use and collects data • CFHE's Health Disparities & Access to Care Team presents "Health Lifestyles", an evidence-based curriculum to YSHCN, one of RI's high smoking populations. • The Tobacco Control Program presents at Dare to Dream, a student leadership conference for YSHCN.
3	a. Increase the percentage of adolescents who have a preventive "well care" visit each year. b. **SPM 3**: Percent of adolescents who receive an annual preventive care visit. c. Data from the three major health plans serving Rhode Island (Blue Cross, United	Major accomplishment is the development of a transition team to include adolescent systems development. • HEALTH worked with external stakeholders (physicians, parents, and adolescents) to develop a report on adolescent access to care identifying opportunities, challenges and recommendations.

	Healthcare and Neighborhood Health Plan of RI) and Cigna indicate that during 2012, 62.5% of RI adolescents received a preventive care visit. The performance objective for 2013 is 67%. HEALTH is currently engaged with a number of stakeholders in increase adolescent well care visits.	• HEALTH successfully implemented an Adolescent Health Summit to identify systems issues to improve the health of adolescents. • Produced a report on research concerning adolescent medical homes in Woonsocket to help facilitate next steps within the community to support medical homes. • Partnered with a pediatrician and Pawtucket high School on an AAP CATCH grant to support the development of an adolescent medical home in an urban high school. • Supported three school based health centers with State community service legislative grant. • Submitted a grant to the Office of the Assistant Secretary for Health, office of Adolescent Health, "Improving Outcomes for Expectant and Parenting Teens: A Comprehensive Approach". • Continued collaboration with the RI Department of Education on products and initiatives that support the link between health and academic achievement.
4	a. Increase the social and emotional health of children and youth with special health care needs. b. **SPM 4**: Percent of high school students with special needs who report feeling sad or hopeless. c. According to the RI YRBS, the percentage of children and youth with special health care needs reporting feeling "sad" or "hopeless" decreased by 7.8%, from 42.1% in 2009 to 38.8% in 2011. Rhode Island is pleased to see a decrease in this percentage and programs are working to continually impact this measure. The 2011 YRBS data surpasses the 2012 annual performance objective of 40.7% and nearly meets the 2013 objective of 38.6%.	OSHCN partners with other state agencies and community providers on implementing RI's system of care for children and youth with special needs: •Developing a framework for positive youth development within the special needs community that provides youth with self-management strategies, opportunities for leadership development and peer mentoring. •Provide opportunities for family and stakeholder participation in statewide and community policies. • Participate on the RI Transition Council to coordinate activities of state agencies & school districts for youth with disabilities transitioning from school to adult life. •Promotes self-determination and leadership development for YSHCN through Dare to Dream initiatives. •Established a Youth Advisory Council to the Office of Special Health Care Needs. • Developed and disseminate adolescent healthcare toolkit used by physicians, CEDARR providers, youth and their families. •Assists families in accessing medical services, special education supports and navigating the system of care through contracting with the RI Parent Information Network through the Pediatric Practice Enhancement Project (PPEP), providing workshops & offering technical assistance to families raising children with special needs.
5	a. Increase the percentage of women who have a preventive care visit in the past year. b. **SPM 5**: Percent of women who have a preventive care visit in the past year. c. Between 2009 and 2012, the percentage of women having a preventive health care visit decreased by 1.7%, from 85.1% to 83.2%.* The state has an active women's health advisory committee to advise the department on priorities and policies to help in attaining	Women's Health Advisory Committee: • Advises HEALTH & Office of Women's Health (OWH) on State priorities and policies. It envisions a Rhode Island where women live to their optimal level by achieving an ideal state of health by promoting a gender-informed, coordinated, comprehensive, primary prevention approach to women's health across the lifespan. • The Office of Women's Health (through the Team Lead for Health Disparities and Access to Care) participates on the Health Insurance Exchange Work Group of Rhode

	the 2013 statewide performance objective of 85.7%. * Note: based on preliminary 2012 BRFSS data	Island's Health Reform Commission. This is the body that recommends minimum benefits to be covered by the RI Health Insurance Exchange. The OWH will advocate for comprehensive women's preventive health services to be required benefits under the state's health insurance exchange. This has tremendous potential to improve the static *percent of women who have had a preventive care visit in the last year.* • The OWH (through the Team Lead for Health Disparities and Access to Care) participates on the Preconception Planning Collaborative and works to improve access to comprehensive, high quality primary care services for women and girls.
6	a. Initiate prenatal home visiting program. b. **SPM 6:** Percent of pregnant women delivering babies served by home visiting. c. During 2012, 120 (10.3%) of the 1,166 at-risk* pregnant women residing in the highest need areas of the state (Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket) were visited during the prenatal period. The 2013 performance objective is 15%. Currently, there are a number of programmatic activities targeting this population. * Note: the at-risk population (denominator) includes those aged less than 25 with less than a high school education and receive Medicaid.	Perinatal and Early Childhood Team: • Continues to support the implementation of prenatal home visiting in RI. The First Connections Home Visiting Program offers prenatal home visiting services on a limited basis to at-risk pregnant women and connects them to prenatal care, medical homes, including finding a pediatrician or primary care provider, and other community based resources and supports (e.g., evidence based parenting and home visiting services). • The Maternal Infant and Early Childhood Home Visiting (MIECHV) Program has been implemented to expand prenatal evidence based home visiting services to low income, pregnant women under the age of 25. Through MIECHV, HEALTH received funding to provide Healthy Families America and Nurse-Family Partnership® in Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket. • HEALTH has received funding to provide Parents as Teachers in Central Falls, Pawtucket, Providence and Woonsocket. The evidence based home visiting programs funded through MIECHV will work with all other home visiting programs and other community based services and supports in those communities and statewide to provide comprehensive services to families most at risk for poor outcomes. • DCFHE will work with local and state partners, including DHS to develop an integrated prenatal referral system with an emphasis on prenatal referrals as well as service coordination.
7	a. Increase access and capacity to evidence-based parent education and family support programs. b. **SPM 7:** Number of parents with children in early childhood that enroll in parenting education/support programs. c. Program data from 2012 show 4.8% of parents were enrolled in such programs. This figure surpasses the 2012 performance objective of 4.5%; the 2013 objective is 5.2%.	During May 2011, HEALTH convened a meeting that highlighted evidence-based programs/practices that improve child health outcomes: • Training program for children, parents and teachers that support the social-emotional competence of children at high risk. • Teen Outreach Program, an evidence-based youth development approach to teen pregnancy prevention for middle and high school students was implemented in Fall 2012. • The Maternal, Infant and Early Childhood Home Visiting Program was implemented to provide evidence based home visiting services to low income, pregnant women under the

		age of 25. Programs being implemented are the Nurse Family Partnership, Parents as Teachers, and Healthy Families America. Programs are serving families in 6 communities • Local Implementation Teams in the 6 core cities meet regularly in order to promote and coordinate the use of evidence-based programs and other local services and programs.
8	a. Adopt social determinants of health into public health practice. b. **SPM 8:** Percent of RI adolescents who report food insecurity. c. Adopting a social determinants framework is a cornerstone of the State's MCH program. Questions that address this performance indicator were included in the 2011 YRBS survey. In 2011, 3.6% of adolescents reported food insecurity, slightly above our 2013 annual performance objective of 3.3%.	Supplemental Nutrition Assistance Program (SNAP) is a food assistance Program through the Department of Human Services. • Those applying must have an income of 185% or less of the Federal Poverty Level and pass a resource test. • RI law requires schools to provide students with access to school breakfasts at all public schools.
9	a. Adopt social determinants of health into public health practice. b. **SPM 9:** Percent of Rhode Island high school students who earn a high school diploma or diploma equivalent in the six core cities. c. Between the academic year 2009 and 2011, the 4-year graduation rate increased by almost 5%, from 63.5% to 66.7%, respectively. During 2012, the rate dropped slightly to 65.6%. The indicator nearly meets the 2013 performance objective of 66.1%. HEALTH will continue to work with State partners to strategize about the most effective activities to achieve the goal of increased high school graduation rates among core city students.	Student achievement and graduation rates can be improved by using data to identify at-risk students during elementary and middle school. By the first quarter of ninth grade or even earlier, course-failure patterns, poor behavior and attendance problems can be used to identify high school students who are "off-track" for graduation. Early warning systems that lead to the provision of personalized and timely academic and social supports can help students get "on-track" for graduation. • HEALTH is implementing Teen Outreach Program, an evidence based youth development curriculum in nine sites statewide. • HEALTH worked with external stakeholders (physicians, parents, and adolescents) to develop a report on adolescent access to care identifying opportunities, challenges and recommendations. • HEALTH successfully implemented an Adolescent Health Summit to identify systems issues to improve the health of adolescents. • Partnered with a pediatrician and Pawtucket high School on an AAP CATCH grant to support the development of an adolescent medical home in an urban high school. • Supported three school based health centers with State community service legislative grant. • Produced a report on research concerning adolescent medical homes in Woonsocket to help facilitate next steps within the community to support medical homes. • Submitted a grant to the Office of the Assistant Secretary for Health, office of Adolescent Health, "Improving Outcomes for Expectant and Parenting Teens: A Comprehensive Approach". Continued collaboration with the RI Department of Education initiatives that support the link between health and academic achievement.

ATTACHMENT V
ORGANIZATIONAL CHARTS:
RHODE ISLAND DEPARTMENT OF HEALTH &
DIVISION OF COMMUNITY FAMILY HEALTH & EQUITY

Department of Health

Organizational Structure

Department Overview

DIRECTOR OF HEALTH

- CHIEF FINANCIAL OFFICER
- ACTING CHIEF OPERATING OFFICER
- PUBLIC INFORMATION OFFICER
- GENERAL COUNSEL

Acting DEPUTY DIRECTOR

ENVIRONMENTAL & HEALTH SERVICES REGULATION

- Drinking Water Quality
- Food Protection
- Health Professions
- Health Systems Development
- Facilities Regulation
- Managed Care Regulation

COMMUNITY, FAMILY HEALTH & EQUITY

- Health Disparities and Access
- Healthy Homes & Environment
- Chronic Care & Disease Management
- Health Promotion & Wellness
- Preventive Services & Community Practice
- Perinatal & Early Childhood Health

OFFICE OF STATE MEDICAL EXAMINERS

HEALTH LABORATORIES

- Environmental Sciences
- Biological Sciences
- Forensic

INFECTIOUS DISEASE AND EPIDEMIOLOGY

PUBLIC HEALTH INFORMATION

- Center for Health Data & Analysis
- Vital Records
- Center for Public Health Communications
- Interim Performance Improvement Manager

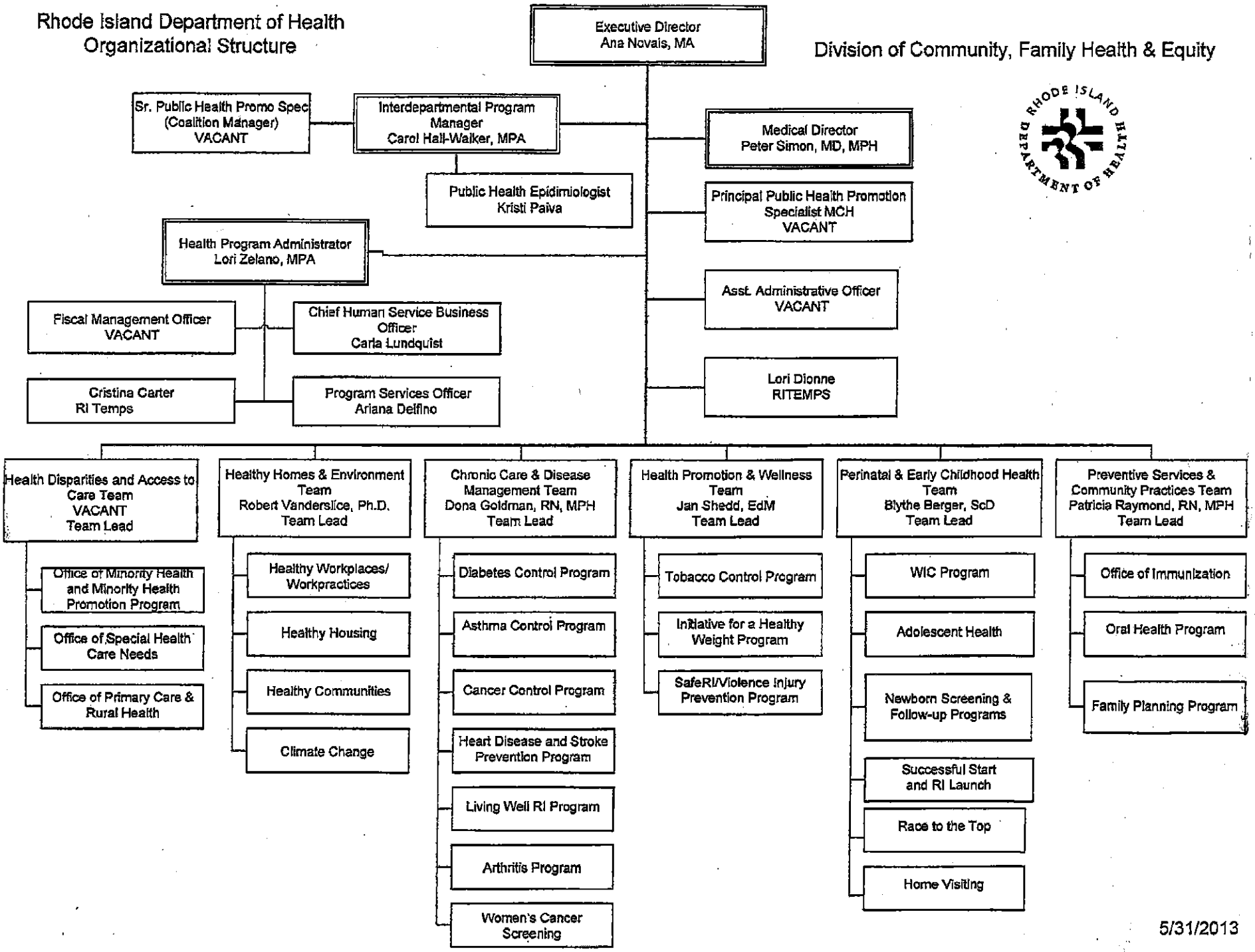
CENTRAL MANAGEMENT

- Center for Emergency Preparedness & Response
- Office of Health Reform and Policy

1/14/2013

Rhode Island Department of Health
Organizational Structure

Division of Community, Family Health & Equity



5/31/2013

/2014/ Forms 3, 4, 5 provide budget and expenditure data for the 2014 application year.

Form 3, State MCH Funding Profile

	FY 2012		FY 2013		FY 2014	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation (Line 1, Form 2)	1,770,159	852,593	1,725,040		1,627,190	
2. Unobligated Balance (Line 2, Form 2)	1,014,131	1,390,436	528,230		441,255	
3. State Funds (Line 3, Form 2)	2,150,006	1,680,985	2,035,853		2,008,389	
4. Local MCH Funds (Line 4, Form 2)	0	0	0		0	
5. Other Funds (Line 5, Form 2)	2,235,641	1,401,320	1,416,184		1,505,729	
6. Program Income (Line 6, Form 2)	17,103,557	17,929,219	19,722,824		24,347,698	
7. Subtotal	24,273,494	23,254,553	25,428,131		29,930,261	
8. Other Federal Funds (Line 10, Form 2)	71,972,325	37,189,172	42,605,664		36,924,037	
9. Total (Line 11, Form 2)	96,245,819	60,443,725	68,033,795		66,854,298	

Form 4, Budget Details By Types of Individuals Served (I) and Sources Of Other Federal Funds (II)

	FY 2012		FY 2013		FY 2014	
I. Federal-State MCH Block Grant	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	640,019	522,935	635,405		651,473	
b. Infants < 1 year old	2,732,099	2,223,881	2,759,324		2,898,188	
c. Children 1	11,793,204	12,545,217	13,568,301		15,335,751	

to 22 years old						
d. Children with Special Health Care Needs	2,329,927	2,406,287	2,446,292		2,519,457	
e. Others	6,507,858	5,250,603	5,673,395		8,209,246	
f. Administration	270,387	305,630	345,414		316,146	
g. SUBTOTAL	24,273,494	23,254,553	25,428,131		29,930,261	
II. Other Federal Funds						
a. SPRANS						
b. SSDI	170,504		171,283		79,542	
c. CISS	182,160		207,355		154,696	
d. Abstinence Education						
e. Healthy Start	48647					
f. EMSC						
g. WIC	26,287,008					
h. AIDS	8,072,014		1,952,052			
i. CDC	26,766,823		28,280,731		26,016,668	
j. Education	37,000		327,828		379,070	
k. Home Visiting			5,907,677		4,948,257	
l. Other						
Admin CYF	447,618		641,774		618,825	
EPA	355,346		315,401		312,559	
Federal Medicaid	3,598,470		398,283		418,120	
Other (OSHA, NESHAP)	2,397,912		2,169,529		2,065,303	
Other HRSA	3,534,880		2,233,751		2,065,303	
III. TOTAL	71,972,325		42,605,664		36,924,037	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

		FY 2012		**FY 2013**		**FY 2014**
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	439,002	143,222	99,495		108,993	
II. Enabling Services	657,325	468,744	323,699		405,825	

III. Population Based Services	17,587,736	17,575,488	19,796,746		23,394,597	
IV. Infrastructure Building Services	5,589,431	5,067,099	5,208,191		6,020,846	
V. Federal-State Title V Block Grant Partnership Total	24,273,494	23,254,553	25,428,131		29,930,261	

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